



CDC Advisory Committee to the Director (ACD) Health Disparities Subcommittee (HDS)

Minutes from the October 19, 2016 Meeting

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Advisory Committee to the Director Health Disparities Subcommittee: Record of the October 19, 2016 Meeting

The Centers for Disease Control and Prevention (CDC) convened a meeting of the Health Disparities Subcommittee (HDS) of its Advisory Committee to the Director (ACD) on October 19, 2016, in the Global Communications Center (GCC) on the Roybal Campus, Clifton Road, Atlanta, Georgia. The agenda included updates from the Office of Minority Health and Health Equity (OMHHE); an overview of the National Center for Health Statistics (NCHS); a Management Analysis and Services Office (MASO) update on the Federal Advisory Committee Act (FACA) nomination process; an overview of the State, Tribal, Local, and Territorial (STLT) Social Determinants of Health (SDOH) Think Tank Collaboration; a funding opportunity announcement (FOA) health equity guidance update and discussion; a discussion of HDS priorities and follow-up actions; and an update on Health Equity Indicators.

Call to Order / Roll Call / Overview of Agenda / HDS Chair Updates

Leandris Liburd, PhD, MPH, MA (Associate Director, OMHHE, CDC / Agency for Toxic Substances and Disease Registry (ATSDR); Designated Federal Officer (DFO) of the HDS, called the meeting to order at 8:10 a.m. on Wednesday, October 19, 2016. She called the roll and established that a quorum of HDS members was present in person and via telephone (N=10). Quorum was maintained throughout the duration of the meeting.

Lynne Richardson, MD, FACEP (Chair, HDS Subcommittee) greeted everyone and welcomed new member, Dr. LaMar Hasbrouck, who is the Executive Director for the National Association of County and City Health Officials (NACCHO). Prior to joining NACCHO, he was with CDC for approximately 12 years followed by serving as the Health Commissioner for a county in Upstate New York, and then as Health Commissioner for the State of Illinois. The new and returning HDS Subcommittee members then introduced themselves and their professional and research focus areas. A participant list is included in this document as Attachment #1.

Dr. Liburd then reviewed the agenda for the day. She reminded everyone that one of the items discussed during the April 2016 HDS meeting was to draft a letter for the change in Administration reflecting the members' support of HDS and other work throughout CDC related to health equity. She requested that the members think about who might wish to take the lead for drafting the letter.

CDC Principal Deputy Director Remarks

Anne Schuchat, MD, BA, (RADM, USPHS; Principal Deputy Director, Office of the Director, CDC / ATSDR) thanked the HDS members for what they have been doing as a subcommittee, as well as what they do professionally for the field in their professional lives. She emphasized that Dr. Liburd has been terrific in briefing her on what is going on, and in leading the OHMME office in terms of moving the agenda forward for CDC. Dr. Schuchat said that in the entirety of her CDC tenure, health equity and reduction of disparities have been enormously important and always are on the agenda. She expressed appreciation for the way the HDS has been bringing in program leaders to listen, learn, and charge them. She expressed her hope that they could continue to be the eyes, ears, and catalysts for CDC doing things in a way that will be impactful. She noted that she switched roles from focusing on the infectious disease prevention agenda as Director of the National Center for Immunization and Respiratory Diseases (NCIRD) about a year ago when she stepped into the Principal Deputy Director role, where she has been

learning so much more about what CDC does across the agency. Dr. Schuchat said that personally in her career, the ability to reduce disparities and to impact high need populations has probably been the most meaningful thing she has gotten to do. She was fortunate to work on things like vaccines, where the Vaccines for Children Program (VCP) has prevented over 300 million illnesses and saved over \$1 trillion dollars. There are gaps and serious health problems between disadvantaged and other populations. She also was able to work on the newborn issue of *Streptococcus* where, by setting a standard of care that everybody could access, there was an 80% narrowing of the gap.

Now that she is learning across CDC about many of the agency's activities related to environmental factors, chronic diseases, and injuries, she has observed that there remain many disparities. In conclusion, she expressed appreciation for the HDS's charge and Dr. Liburd's follow-through in helping develop a framework for the agency that can help lead the way to address the workforce in terms of the future workforce with the CDC Undergraduate Public Health Scholars (CUPS) program and current workforce with Project Officer and Supervisor training, and trying to imbed in CDC's programs doing things in a way that will be impactful. While Dr. Richardson represents the HDS on the ACD and has a strong voice there, Dr. Schuchat said she wanted to spend some time with the group as a leader in the agency to listen and to hear directly from the HDS their recommendations and advice. In addition, she wanted to publicly express her appreciation for the work of the HDS and their input.

Discussion Points

Regarding an inquiry about bringing her own interests to the position and what other agendas might lead her moving forward, Dr. Schuchat replied that her portfolio is what Dr. Frieden would like it to be rather than a lot of her own special projects. But like Dr. Frieden, she is very committed to measurement and follow-through. They are just now beginning the Healthy People 2030 process. The work that the HDS has been doing with regard to indicators for health equity is very timely as they enter that process. The ability to make sure that the right items are being measured is very important. In immunization, that was key. When they stopped the predecessor to the National Immunization Survey (NIS), they lost ground in measles coverage and realized it because of a huge outbreak. Those types of infrastructure issues where strong metrics are built into the way the work is done in order to measure whether progress is being made can help identify high risk populations and/or the strategies that are not working. She also is committed to community engagement. Whether it is the way CDC conducted its Ebola trial in Sierra Leone or the way that they work with communities through partners, as an agency they need to be supporting efforts to understand community issues to move things forward.

Dr. Marguerite Ro emphasized that the HDS members have really enjoyed working with Dr. Liburd and have appreciated seeing the OMHHE office grow and hope that in future Administrations the office will be sustained and continue to grow in terms of its impact in embedding health equity into CDC. Thinking about Dr. Schuchat's mention of chronic disease issues, Dr. Ro said she thought one of the opportunities for the future would be looking upstream at the SDOH. This has been a longstanding conversation with HDS and OMHHE. Beyond measurement is the question regarding strategies that are effective and impactful, and the ability to evaluate and understand those. Much of that has to do with innovation. When working at intersections such as health and housing or health and education, evaluation is such an essential component. But, having an equity lens in that evaluation is really important. To the degree that OMHHE can help promote, conduct, or support those evaluations would be tremendously helpful to the field.

Dr. Schuchat agreed, pointing out that they suffer from the length of funding cycles and the limits of what is included in them in terms of being able to really measure changes they are trying to support when looking at some of the upstream factors. She has been able to meet with folks in Seattle-King County and see the incredible outreach efforts there. The past week she was in Rochester, New York and saw their Center for Community Health and learned about the Teen Health and Success Partnership, which was one of the most exciting things she heard about because they achieved 100% graduation rates among very high risk teens. CDC is struggling as an agency to make sure that funding is implemented long enough so they can build in the right kinds of evaluation. Dr. Liburd's group and CDC's Performance and Evaluation Office have been looking at FOAs and how the evaluation piece is built in. It is difficult because there are insufficient funds for the interpretive services that are needed. Dr. Frieden likes to say that the way you get an effective agency is because outside people are pushing you to do the right thing, so that is a key element.

Ms. Mildred Thompson said she was pleased to see the way in which the CDC is embracing the idea of health equity, and hearing that the agency is very proud of the work that Dr. Liburd and her unit are doing. To the degree that this is not viewed as a separate center, but that the idea should be a thread throughout the entire agency, she stressed the importance of paying attention to where there are opportunities for addressing health inequities in all of the areas across CDC. She said she was curious to know to what degree that conversation has been viewed in this way, and how they are looking at framing the work that includes the health equity lens throughout the entire agency.

Dr. Schuchat agreed that this is part of all of their work, and thinks that Division and Center Directors view it that way. There is obviously expertise in Dr. Liburd's team that helps. Having each Center Director come in to speak with the HDS is beneficial in terms of them thinking about how to get the job done. They are thinking about the highest risk and the greatest need. Dr. Schuchat said she used to do a lot of global immunization, and she always uses the example of UNICEF that embraces starting at the hardest places versus the national average. You have to go where it is impossible and really change the strategy when you realize that you are trying to achieve equity, not just a reasonable average. That is very much the case, not just in the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), but also throughout the chronic and infectious disease areas. While she thinks it is embedded, the advice about ensuring this is important because the agency may think they are doing better than they are. This is another reason she likes measurement. It is more than just the numbers. CDC's credibility and reputation are very important, and the agency needs the outside community to help keep them honest.

Dr. Richardson noted that when HDS meets with the Center Directors, they are struck by the tremendous amount of high quality work they are doing, and they are focused on areas of high risk and need, but she called attention to one of the recommendations of the subcommittee that it is not enough just to do world class public health. Sometimes, it really takes tailored, targeted interventions to address certain communities or certain groups within communities. One thing that almost always comes up in their conversations is the insufficient focus on who is being left behind, who is being differentially impacted, and who is not being reached. This is the piece they often do not get as much information about and there has not been as much attention to as they would have liked. She does think that health equity is part of the culture of the organization, but there is a need for continued understanding about what it means to do that work. Dr. Liburd and her staff understand and articulate that, and that is where the next level of understanding needs to come from—that it is not enough just to be aware and it is not enough to do good. It is about particular strategies.

Dr. Schuchat said she would be interested in HDS's thoughts and advice about what seemed to be a natural tension or intrinsic dilemma in some of what they are trying to do. Ideally, they are providing flexibility at the community, state, or local level to recognize the cultural issues that would be important to impact change. CDC is focused on measurement, but that is costly to do at the granular level to understand what is going on. They always want to put more money into the program than a study of the program, but they do not know whether the program worked without studying it. In addition, the country is large. Every county and practice is different, making it difficult to know if what works in one place is generalizable to others. Getting the balance right between allocating resources for services versus understanding is challenging. Moreover, the agency also has Congressional constraints or directions that can be highly directive. They are mindful of wanting to make change, but not spend all of their time building, and destroying, and building and destroying.

With a new administration coming in, Dr. Lichtveld pointed out that the members are anticipating how CDC and HDS will move ahead. The struggle is that if it is embedded and is everywhere, it is also nowhere. If it is special, it is marginalized. She asked how to balance that, how to overcome that stressor in terms of health equity, and how to present it to the new Administration. She fully agreed that evaluation and measurement are critical, but emphasized that if they are not collecting the right data from the start, it is "garbage in, garbage out." The commitment to collect the right data is critical. If they do not train the new workforce to look through the lens of culture and to be analytically driven, the right data will never be collected to do the right evaluation, have the correct monitoring, or the opportunity to intervene and have an impact. This is a cascade that really starts at the roots. For all of the decades Dr. Lichtveld has been working in health disparities, it seemed to her that they have consistently done things symptomatically rather than causally. With the new Administration coming in, from a strategic and policy perspective, she thought they would have another opportunity to do this right, to be strategic about it, and to be analytical about it.

Dr. Schuchat appreciated Dr. Lichtveld's comments about everywhere and nowhere. Leadership is critical. The top folks have to be committed to, talk about, and expect these issues to be addressed. Second is accountability, which she links to metrics. If they are measuring it, they are going to care about it. In terms of workplace training, Dr. Schuchat's mom is a Cultural Anthropologist, and the idea of the lens that is brought to the issue is how she was raised. Certainly, healthcare is changing and it is imperative to have a fit for purpose workforce. She thinks this is an exciting time where public health is such a popular course of study for youth today, and there is talent in all sorts of places. CDC has an undergraduate program with CUPS and the Public Health Associates Program (PHAP) that they can tap into to interest people in focusing their careers on the public health workforce. If the new Administration is focusing on infrastructure, that is an opportunity. It is not going to happen overnight, but some of them have been around long enough to see some of these efforts "bear fruit."

Dr. LaMar Hasbrouck pointed out that a lot of NACCHO's focus is on the transition as well. Given that she has been with CDC for 29 years, he asked Dr. Schuchat to discuss the mechanics of the transition with a new Director coming in and to forecast how that works and how a topic such as health equity can get on the "front burner" before the new leadership so that it can be woven into the fabric of the Winnable Battles or whatever the new mission might be.

Dr. Schuchat replied that CDC is different from a lot of agencies in that they have only a single position that is considered a politically appointed position, the Director, and that politically appointed position is not Senate-confirmed. So, it is in a different category and they may or may not have a new Director. HHS will have changes. There is a major effort underway that is quite formalized wherein the two

parties' transition teams are meeting with the current government and the official transition teams within each department. For the HHS Transition Team, career staff would be feeding into those meetings. CDC's Chief Operating Officer (COO), Sherri Berger, represents CDC on the HHS Transition Team. Within CDC, preparation is being made of factual type briefing materials that the CDC Transition Team will use to brief others. They expect that each of the agencies will be identifying key issues for the first 100 days. Really, all of the outside world is influencing the transition team as well. No one really knows exactly how this is going to work beyond "organized chaos." There is a lot of paperwork being developed. Outside groups are probably involved more in policy development, while in-house is more factual.

Ms. Wilson reiterated that one of the concerns raised earlier regarded the cost of collecting granular data. There was a great presentation the day before about reviewing various CDC surveillance systems and how they collect race, ethnicity, primary language, country of birth, and immigration status. She said she would share these data with the rest of the group. There was an N of 125 that showed that systems do much better with race and ethnicity, but are not so great with primary language, country of origin, and immigration status. In order to tackle disparities, understand the proxy for health equity, having culturally tailored interventions, and disaggregating data, she asked what CDC's plan is to start trying to collect some of those data.

Dr. Schuchat said she thought the upcoming presentation from the National Center for Health Statistics (NCHS) would be beneficial. She clarified that some of CDC's systems that are using available data may not have variables such as immigration status because they do not want to have barriers to care. That is not one of the questions asked in the VFC program. It is just, "Do you have insurance? Yes / No." To avoid barriers, they do not care where someone is from and whether they are in the US legally or not. Dr. Rothwell will be leading the charge on making sure that CDC, as an agency, is addressing this. She expressed her appreciation again for all that HDS is doing, as well as for their comments during this session.

OMHHE Updates / New Staff Introductions / Strategic Planning

Dr. Liburd shared OMHHE's work since the last HDS meeting in April 2016, as well as the office's progress toward achieving the recommendations forwarded by HDS and ACD. She began by sharing some key activities in which OMHHE has been involved since the last HDS meeting in April 2016.

In June, they had their 5th class of the CUPS program. Students came to Atlanta for several days of orientation. OMHHE is completing the five years of the program having been able to expose 913 students over the last 5 years to a public health experience. These 913 students were selected from among an applicant pool of over 16,000. They are very excited about going forward with the program in 2017, and are continuing to work with the same grantees at the University of Michigan, Columbia University, Morehouse College, and Kennedy Krieger Institute.

In June, OMHHE also participated in the Congressional Briefing: Advancing Health Equity & Optimal Health for All, which was sponsored by Senator Al Franken of Minnesota and cosponsored by the Congressional Public Health Caucus. There was standing room only and the briefing was very well-received. The lead organizer was the Association of State and Territorial Health Officials (ASTHO) and Minnesota Department of Health (MDH) Commissioner, Dr. Edward Ehlinger whose Presidential challenge this year has been on advancing health equity and optimal health for all.

In July, OMHHE launched the Women's Health Lecture Series. The first lecture focused on intimate partner violence (IPV). Lectures also were presented in July and September. OMHHE also released the Conversations in Equity Blog: African Americans and Tobacco Use in July.

In August, OMHHE hosted its first external webinar to promote the *Morbidity and Mortality Weekly Report (MMWR)* supplement and highlight programs that have been effective in reducing or eliminating health disparities. The webinar was very popular, reaching the maximum number of attendees with 200 participants.

In September, Dr. Liburd attended a meeting that was cosponsored by The Joint Commission and the American Hospital Association (AHA) on health equity. She thought that was a very forward-thinking opportunity. Hospitals are now being charged with examining health equity in terms of the way they provide care.

Also in September, Dr. Liburd participated in the Precision Medicine Initiative (PMI) Cohort Program announced in President Obama's 2015 State of the Union Address, which includes a full set of White House programs. The PMI Cohort Program's key components include the Data and Research Support Center, the Biobank, the Participant Technologies Center, and Healthcare Provider Organizations. The program seeks to enroll one million or more participants in a longitudinal research cohort to improve the ability to prevent and treat disease based on individual differences in genetics, environment, and lifestyle. The program aims to reflect the diversity of America. The September PMI meeting, with a focus on community partners, convened approximately 170 community representative to discuss the initiative, with a goal of ensuring that the cohort is diverse when the study is actually launched.

There is an activity that is being sponsored by the Office of the Associate Director for Policy (OADP), the Office for State, Tribal, Local and Territorial Support (OSTLTS), and OMHHE that is called "Social Determinants of Health with Authors" where Dr. Ana Penman-Aguilar presented her paper on measurement in September.

The State of Health Equity (SHE) Forum at CDC: Broadening the Health Equity Infrastructure at CDC was convened on October 18, 2016. There were over 170 pre-registrations. Dr. Liburd said that she was very excited that Ms. Cheri Wilson was there representing the HDS. The theme of this year's forum was Broadening the Health Equity Infrastructure at CDC, one of the four components to the model being developed. The forum featured three panels: Strengthening Leadership for Greater Accountability, Developing a Diverse and Culturally Competent Workforce, and Improving the Infrastructure for Better Data Collection. The panels consisted of speakers from a broad spectrum of backgrounds and disciplines, each offering expertise and guidance on how to implement health equity strategies into public health practice.

There was a video opening by Dr. Frieden, and Dr. Liburd presented opening remarks. Dr. Edward Ehlinger, gave a very compelling presentation about the work that they are doing in Minnesota and the leadership that is needed. The Director of CDC's National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention (NCHHSTP), Dr. Jonathan Mermin, discussed leadership from the standpoint of his center. CDC's Associate Director for Policy, Mr. John Auerbach, was a discussant and raised several questions that need to be pursued within the agency in order to elevate the issues of leadership pertaining to health equity. Regional Minority Health Consultant (RMHC) from the HHS Regional Office for Region 4, CAPT Arlene Lester, gave a presentation about resources that are available from HHS, particularly the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (The

National CLAS Standards) standards and the [Think Cultural Health Website](#). They have invested a considerable amount of time and resources updating and being responsive. The discussants were NCHHSTP Deputy Director, Dr. Hazel Dean, and the Chief Diversity Officer, Dr. James Nelson. One of the data presenters was Dr. Alfonso Rodriguez-Lainz, who is with the Division of Global Migration and Quarantine (DGMQ) in the National Center for Emerging and Zoonotic Infectious Diseases (NCEZID). Dr. Rodriguez-Lainz is based out of California, so he is up-close and personal with a lot of these issues, particularly regarding language, migration status, whether the correct data are being collected to respond appropriately to populations. Also present was Dr. Marjory Givens, who is an Associate Scientist with the Robert Wood Johnson Foundation (RWJF)-funded County Health Rankings & Roadmaps program at the University of Wisconsin Population Health Institute (UWPHI), discussed the County Health Rankings & Roadmaps program. They are in the process of updating that program to acquire even more granular data from local communities, so that they can respond to health equity issues. CDC's Deputy Director for Public Health Scientific Services, Dr. Chesley Richards, also presented. Dr. Liburd emphasized that the summit was very enriching and people were impressed that these dialogues are occurring and that they are very rigorous.

Also planned for October is the next Diversity and Inclusion Executive Steering Committee meeting, which will be convened on October 25, 2016.

The second CDC Diversity Culture Audit has been completed. This is an examination of the work environment, how inclusive it is, and other concerns people have about working at CDC. CDC is the first federal agency to perform a diversity culture audit. The audit was conducted from December 2015 through August 2016. This multi-pronged study included an online survey for all CDC staff, focus groups, and senior level interviews (N=34). Currently, the findings are being reviewed and shared with the leadership. They will be embarking on a series of "road shows" around the agency to share the findings.

In terms of the Language Access Plan, Dr. Liburd said she was very excited that they were probably within days of having a Language Access Policy for the agency. This has been several years in the making and comes just in time for the release of Section 1557 Non-Discrimination Rule. Within that rule, CDC is expected to provide language interpretation services for the top 15 languages spoken around the country. There are other aspects of non-discrimination in terms of sex and gender identity, so OMHHE is coordinating the agency's response and is working on a matrix report that will be submitted to the Office of Civil Rights (OCR) in a matter of a few weeks. OMHHE will keep the HDS informed about this.

Dr. Liburd introduced and welcomed four new members to the OMHHE staff:



Sharon Coleman

Sharon Coleman joined OMHHE as the Associate Director for Policy (ADP) in May 2016. She is responsible for providing guidance on all OMHHE policy-related activities including policy analysis, budget formulation, legislative tracking and analysis, and partnership development. Ms. Coleman has over 20 years of policy experience with the federal government. Immediately prior to joining

OMHHE, she served as the Associate Director for Policy and Partnerships in the National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Division of Community Health (DCH). She has served in multiple policy positions in multiple Centers, Institutes, and Offices (CIOs) during her tenure with CDC, including the Office of Surveillance, Epidemiology and Laboratory Services (OSELs), the National Center for Public Health Informatics (NCPHI), and the Public Health Practice Program Office (PHPPO). Sharon has also held positions with the US Environmental Protection Agency (EPA) and the Internal Revenue Service (IRS).



Melanie Duckworth, PhD

Dr. Melanie Duckworth is on detail as the Senior Advisor to the Director, OMHHE. Previously, she was the Associate Director for Senior Liaison Services within the OSTLTS in the Customized Support for Health Officials (CSHO) Unit. Additional previous CDC experiences include: Acting Branch Chief, DCH / NCCDPHP; Senior Liaison Officer assigned to the Office of Noncommunicable Diseases, Injury and Environmental Health (ONDIEH); Acting Director for the Tribal Support Unit; State Emergency Preparedness Officer, Senior Management Official (SMO) assigned to the Florida Department of Health (FDOH) in Tallahassee; and Public Health Advisor within the Global AIDS Program (GAP) assigned to the Ministry of Health (MoH) in Pretoria, South Africa.

She also served as the Southern Africa Regional Advisor on activities related to HIV/AIDS prevention, with a focus on HIV/AIDS treatment and increasing voluntary counseling and testing. Dr. Duckworth spent several years as a Health Scientist within the Office of Global Health (OGH) Policy and Research Unit where she supported field activities and policy development programs. She began her public health career as a Presidential Management Intern/Fellow, which provided her the opportunity to work with several CDC programs. Dr. Duckworth earned her undergraduate degree in Psychology from Xavier University of Louisiana, Master's in Social Welfare from the University of California at Berkeley, PhD in Social Policy from Clark Atlanta University, and a Master's in Education from Central Michigan University.



Jeffrey E. Hall, PhD, MSPH

Dr. Jeffrey Hall serves as Deputy Associate Director for Science in OMHHE. He assists with the provision of leadership and consultation across a broad range of science, research, evaluation, and practice issues to promote the elimination of health disparities and the achievement of health equity. He also conducts

research to develop or enhance local, state, and national systems or capacities for measuring and monitoring progress towards health equity.

Dr. Hall was previously a lead behavioral scientist at the Surveillance Branch (SB) of the Division of Violence Prevention (DVP) of CDC's NCIPC. His professional interests include applications of developmental epidemiology and social psychology within violence prevention, structural, and environmental methods for reducing violence-related health disparities, and community-based models for violence surveillance, research, and prevention. His work has focused on topics across the life span, including infant homicide, youth and young adult violence, and elder abuse. Lastly, Dr. Hall is a Medical Sociologist by training. He also holds degrees in Epidemiology, General Sociology, and Psychology—all from the University of Alabama at Birmingham.



Pattie Tucker, RN, MPH, DrPH

Dr. Pattie Tucker comes to the Office of Women's Health (OWH) from the NCCDPHP /DCH where she served as Acting Associate Director for Health Equity. As a member of DCH's senior leadership team, she was recognized by staff, awardees, stakeholders, and partners as a subject matter expert (SME) in the implementation and evaluation of culturally appropriate interventions to address SDOH in vulnerable populations. Dr. Tucker previously served as Director of the Racial and Ethnic Approaches to Community Health (REACH) Program, which is the cornerstone of CDC's efforts to eliminate racial and ethnic health disparities among African Americans, American Indians, Hispanics/Latinos, Asian Americans, Alaska Natives and Pacific Islanders in the US. She also is a member of the Institute of Medicine (IOM) Roundtable on the Promotion of Health Equity and the Elimination of Health Disparities.

In addition to her domestic leadership in health equity, she has worked internationally to reduce health inequalities. She provided expert consultation and technical assistance to the Center for Infectious Diseases (CID) in Zambia in their community efforts to screen and treat women with and at risk for cervical cancer. As lead Health Scientist, she worked with the Namibia Ministry of Health and Social Services on their National HIV Sentinel Serosurveillance study of pregnant women. Most recently, she was deployed to Sierra Leone to assist in the Ebola outbreak. She also was a member of the CDC team who trained healthcare workers from countries around the globe who were being deployed to West Africa to work in Ebola treatment units.

Prior to joining CDC in 1991, Dr. Tucker spent over 10 years serving vulnerable populations, including Medicaid recipients and others seeking services at a county health department and healthcare at a local teaching hospital. As a Nurse Program Specialist with a state public health department, she provided guidance to a statewide network of nurses and social workers working with older adults needing assistance with navigating various public services and health delivery systems. Dr. Tucker's career spans from clinician for women and children to consultant on evidence- and practice-based strategies designed to promote healthy lifestyles and disease prevention domestically and internationally. She has co-authored several book chapters and published a number of peer-reviewed articles focused on

intervening on the social determinants and evaluation of interventions designed to eliminate racial and ethnic health disparities. She holds a Doctorate of Public Health from the University of Alabama at Birmingham in Maternal and Child Health Epidemiology, a Master's of Public Health in Policy and Management from Emory University, and a Bachelor of Science in Nursing from Florida A & M University.

In addition, OMHHE set forward an objective this year to “hold its arms out” and find some great people. Therefore, they have been able to welcome a number of new people, including the following:

- Britni Ashkinazy (Science)
- Emmanuel Bemou (Administrative)
- Sonia Croft (Administrative)
- David Delozier (Initiatives and Partnerships)
- Corinne Fukayama (Initiatives and Partnerships)
- Taylor Harris (Science)
- Nma Ohiaeri (Initiatives and Partnerships)
- Desireé Robinson (Communications)
- Glynnis Taylor (Initiatives and Partnerships)

OMHHE also bid farewell to three staff members, the first two of whom moved on to other roles and the third who retired:

- Eva De Vallescar (Communications)
- Domenica Niño (Communications)
- George Roberts (Senior Advisor)

The National Academy of Medicine (NAM) announced on October 17, 2016 the election of 70 regular members and 9 international members during its annual meeting. Dr. Liburd congratulated Drs. Lichtveld and Richardson, who were elected to NAM. Election to the Academy is considered one of the highest honors in the fields of health and medicine and recognizes individuals who have demonstrated outstanding professional achievement and commitment to service.

Dr. Liburd shared the following graphic OMHHE created to represent the emerging Health Equity Framework for Action:



Infrastructure is at the bottom, given that there must be a strong infrastructure for health equity to undergird programs, measurement, and policies. They have a theme of driving toward health equity, illustrated by a road and the sunrise representing arriving at or achieving health equity. Health equity is achieved when everybody has the opportunity to be as healthy as possible. The previous day, there was quite a conversation about equal opportunity versus equal health outcomes, and all of those things that actually matter in the scientific context. But, without these opportunities, people do not have a chance for equity. Dr. Liburd described the goals for each of the Operating Principles of the framework, which include: Measurement, Essential Program Elements, Policy, and Infrastructure.

Measurement

- Identify characteristics of groups of people that are associated with more/less power and privilege or with higher/lower social position. Measure differences in health and its determinants (including social determinants) associated with these characteristics and assess change over time.
- Groups to be compared should be simultaneously classified by multiple social statuses. In other words, it is not enough to look at one dimension of power/privilege or social position in isolation.
- Social and structural determinants of health should be assessed, and multiple levels of measurement (e.g., individual, family, census block or tract, county, state) should be considered.
- The rationale for methodological choices made and measures chosen should be made explicit by those who design data systems to monitor indicators of health equity.
- Although rigor always comes first, it is possible to consider stakeholders' communication needs in the selection of analytic methods.

Dr. Liburd noted that someone wrote a challenge to some of the methods that were described in the article, and there has been a response from CDC to that challenge. She will provide this information to the HDS members.

Essential Program Elements

- Consider socio-demographic characteristics
- Understand the evidence base for health disparities and inequities
- Leverage multi-sectoral collaboration
- Mobilize community engagement
- Use clustered interventions, engage with communities
- Plan and evaluate rigorously

Policy

- Maximize existing national policy strategies
- Use a SDOH framework to analyze problems and generate policy options
- Develop a Health in All Policies (HiAP) framework
- Use Health Equity Impact Assessment as a tool to get to HiAP

Infrastructure

- Develop/maintain a culturally and linguistically competent workforce
- Develop appropriate data systems
- Assure accountability at high levels of the organization
- Effective and consistent leadership at high levels of the organization

OMHHE has not completed the process of articulating the framework for action. They are working to organize this large arena of health equity to facilitate action primarily, but not exclusively, from the standpoint of governmental public health. The approach to the development of the framework was driven by core features of public health practice – which is also how the CDC SHE Forums were planned. What they have for each of the Operating Principles is based on the best available evidence from the literature. The orientation to all of the planning has kept in mind what is actionable at the state and local levels. Dr. Liburd expressed gratitude to Dr. Hasbrouck for letting her be part of the NACCHO annual meeting where she was able to share this perspective. This information also was shared during the ASTHO Policy Summit in September 2016, as well as during the 5th Annual SHE Forum on October 18, 2016 at CDC. Dr. Liburd indicated that she had the first draft of the *Report from the National Leadership Academy on Health Equity: Strengthening the Capacity of Public Health Departments to Advance Health Equity* from the April 11-12, 2016 ASTHO meeting, which sets forth recommendations for strengthening the capacity of public health departments to advance health equity and operationalize the CDC Health Equity Framework. The framework was shared during this meeting, where there were representatives from the state and local levels who provided comments and recommendations. The next step is for Drs. Liburd, Penman-Aguilar, Hall, and Wilkins to create a single publication that pulls together the Operating Principles into one framework and incorporates the additional perspectives and feedback.

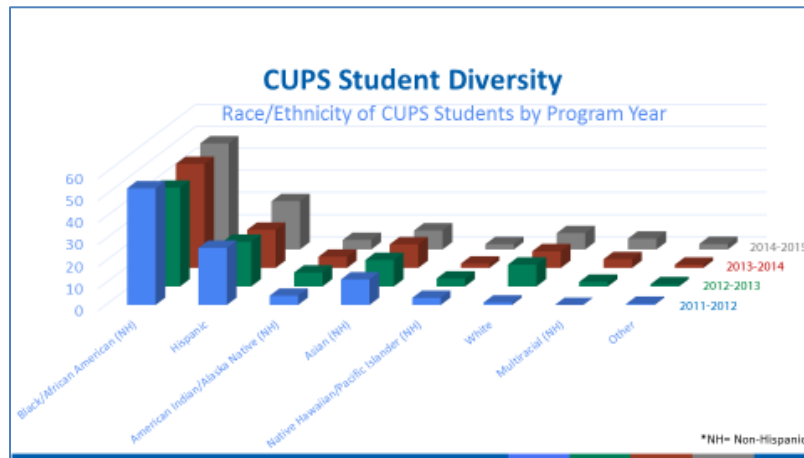
Regarding the HDS recommendation related to health equity indicators, OMHHE shared during the last meeting that the National Collaborative for Health Equity (NCHE) had been funded by the RWJF to establish health equity indicators and have created a national advisory board. Given that NCHE had a structure already established, OMHHE decided to collaborate with them, and they have been pursuing this strategy since that time. Dr. Penman-Aguilar and several of the Scientists at NCHS have been collaborating with the NCHE to examine measurement. They have grappled with a number of methodological and analytical issues together. OMHHE is very excited about this work. There have been a number of milestones. OMHHE provided a technical consultation that, per NCHE, enabled rapid progress on the initial measurement domains of health outcomes and income. By December 2016, a “teaser” analysis of health outcomes and income will be completed and released. Within 3-6 months, a framing document will be developed and published in the literature to describe how the health indicators were created. The list of indicators is anticipated to be released by June 2017.

OMHHE discovered in the Healthy People 2020 database workforce indicators, so the decision was made to develop a public health and healthcare workforce diversity indicator that frames diversity as a SDOH and examines it through a health equity lens. One of the students who has been working with OMHHE for several months has been involved in conducting a literature review on workforce diversity indicators, which has been completed. The hope is to have the indicator designed by June 2017, and to develop a report on it by October 2017.

In terms of the workforce training and development recommendation, OMHHE staff has been collaborating with NCCDPHP on the planning and implementation of a new course, *Project Officers Advancing Health Equity*. Materials developed for the course included Key Health Equity Resources, Resources for Identifying and Understanding Health Inequities, Health Equity Checklist: Considering Health Equity in the Strategy Development Process, and CDC’s Division of Community Health Twin Approach to Health Equity. OMHHE staff is reviewing health equity competencies, using criteria developed from this training as a base to target the overall Project Officer training component for the agency and to assist in future curriculum design. Competencies will define who will receive future training and the options of dissemination of the training. Once developed, this process will allow

the office to address what the minimum or acceptable standards are for what health equity looks like in the workforce.

Dr. Liburd reminded everyone that OMHHE has completed five years with the CUPS program with just over 900 students having participated. The following graph depicts the breakdown of racial/ethnic diversity within the programs:



Dr. Liburd concluded that while they certainly can work to achieve more equity, coming out of the first five years of a very targeted effort to increase diversity and participation of under-represented students in public health, OMHHE feels that they have done well in ensuring that there has been a diverse pool of students.

Discussion Points

Dr. Richardson requested that the agenda and slide sets from the SHE Forum be shared with the HDS members.

Coming from the perspective and thinking through how this framework gets connected to work that is occurring throughout the nation regarding foundational public health services and accreditation, Dr. Ro emphasized that the more they can tie the health equity framework back to what it means to resource public health is really important. Some of this clearly is focused at the national level, but there is a translation and connection. In her mind this is a pivotal moment, as they have gone through the first wave of foundational public health services into the next era of work where people are becoming more serious about it beyond concept to what it means in terms of budgets and implementation. This is great timing, but she stressed that it is important to figure out what the connectors are as they bring this framework forward.

Regarding the Diversity Culture Audit, Dr. Hasbrouck asked whether an instrument is available for those who might want to replicate it and how they are sharing it during the “road show” (e.g., slides, infographic, other tools).

Dr. Liburd replied that they worked through a contractor and have the instrument, the interview guide for executive leaders, et cetera. They are analyzing the data for each CIO, are in the process of writing an Executive Summary, and there are slides. Once those are final, OMHHE can share them. The “road shows” will include slides and are open to any CDC staff.

Dr. Marguerite Ro suggested that the Health Equity Framework should be presented to philanthropy groups, which have done a lot to push and catalyze work around health equity. Grantmakers in Health (GIH) would be a natural convening where a presentation such as this might be beneficial.

Dr. Will Ross asked how CDC is aligned with the effort regarding the accreditation of public health agencies in terms of whether they are inputting data directly or sitting at the table as an advisory.

Dr. Liburd replied that OSTLTS is playing a very pivotal role with the Public Health Accreditation Board (PHAB). Liza Corso is leading CDC's participation in the public health accreditation process. She is one of the people OHMME is interested in interacting with closely, particularly with regard to this model and how that can help to inform the health equity component of the accreditation process.

Dr. Sonja Hutchins indicated that part of her training is in public health leadership. She has been following the standards and collaborating with her colleagues in OSTLTS over the past 10 years. Liza Corso, for example, has been evaluating the public health infrastructure and performance over the 10 years while building this accreditation initiative. They are very happy that it has come to fruition. Approximately 100 state and local public health agencies are now accredited. That is good news. Part of the standards include cultural competency, and there is language pertaining to health equity. Obviously, there are more opportunities to include health equity in the standards. They have community assessments and community strategic plans. There are many opportunities as more agencies become accredited. This is an exciting opportunity in public health. Those who have been working on this for over a decade are very happy to see this initiative go forward, and more and more public agencies across the country are becoming accredited.

With regard to a question pertaining to whether the framework is final, Dr. Liburd indicated that it is not as they are still receiving feedback.

Dr. Lichtveld emphasized that this is a time during which there needs to be increased visibility; that is, November through January during the Presidential transition. The more OMHHE can use the HDS members as its ambassadors wherever they are and speak, the more they can augment the effort. It would be beneficial to be armed with a set of slides about the framework so that they can share them wherever they go. She noted that while they talked about *equity* and *opportunity*, a term that is increasingly coming up that was not discussed is *security* with respect to housing, food, et cetera. While there might be opportunity and equity, there may not necessarily be security. Opportunity and equity must be addressed in the context of security as well. Also, it is one thing to have community engagement, but it is another for it to be really participatory. A number of agencies are embracing the notion of "citizen science," so this is a time to be vocal about and embrace citizen science. She explained that citizen science uses locally collected data to make decisions, and shared an example from New Orleans to illustrate how using citizen data resulted in a different outcome than a risk assessment would have. The power of locally collected data is enormous in terms of making local decisions. The Affordable Care Act (ACA) has now legitimized the Community Health Worker (CHW) as a health partner. She also stressed that global health inequity is an immense issue.

Dr. Ro said that while she appreciated the concept, her concern with the term "citizen science" was for folks who do not see themselves or, more importantly, other people do not recognize them as citizens.

Dr. Liburd added that she was invited to a meeting by the Aspen Institute on the issue of citizen science. That language also is being used by the Precision Medicine Initiative Cohort. It is an emerging term.

Dr. Richardson noted that she heard several potential action items for the HDS during this presentation and discussion, which they would return to in the afternoon. These included consideration of formally endorsing the following: 1) the Health Equity Framework for Action; 2) collaboration on health equity indicators; and 3) embedding health equity into the accreditation process and standards.

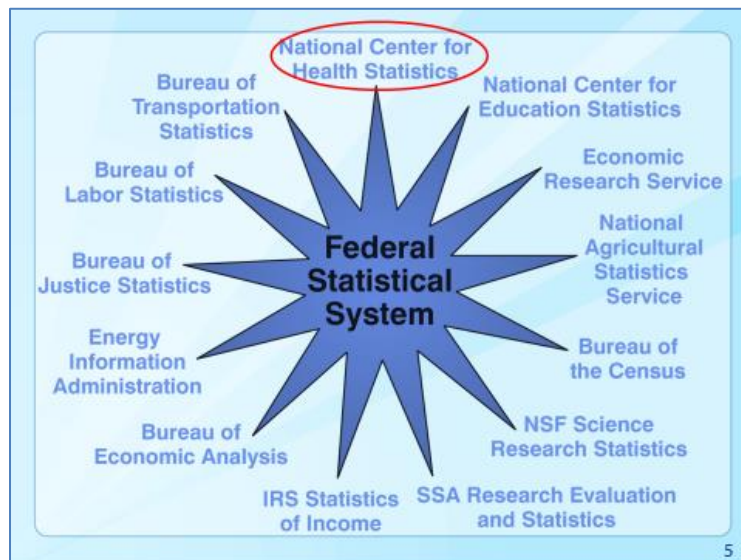
Dr. Mary Garza said she had reviewed and really liked the framework, and emphasized that OMHHE should use the HDS members as ambassadors because they are teaching the next generation of public health leaders. This would be great to disseminate within curriculums, et cetera.

National Center for Health Statistics Overview

Charles Rothwell, MBA, MS (Director, NCHS) presented an overview of NCHS and its data systems; Health, United States 2015, with its special feature on health disparities; Healthy People 2020's Health Disparities Tool; and other NCHS research on disparities in terms of methods and measures, peer-reviewed research, data briefs, and data visualization.

He explained that NCHS is a part of CDC, since it was integrated with CDC in 1987. The main NCHS office is in Hyattsville, Maryland and data processing is in Research Triangle Park, North Carolina. NCHS's functions are to: 1) monitor the nation's health by collecting, analyzing, and disseminating health data; 2) inform actions and policies to improve the health of the American people; 3) compare across time, populations, providers, and geographic areas; and 4) identify health problems, risk factors, and disease patterns.

NCHS wears two separate hats. One is as a CDC center, while the other is in a semi-independent role as one of 13 agencies in the Federal Statistical System (FSS) subject to a different set of policies and regulations as depicted in the following graphic:



NCHS is subject to specific rules in order to ensure that these systems are neutral, and independent of the political process. There are occasions when there are constraints, which insulate NCHS from external pressures. The Director of NCHS also is a Statistical Advisor to the Secretary. The director of the NCHS has an independent role. NCHS has a dual function in Healthy People: 1) as a CDC center and data provider / technical expertise on the data; 2) because Healthy People is an HHS initiative, NCHS is a neutral objective agency. The status of NCHS is distinct.

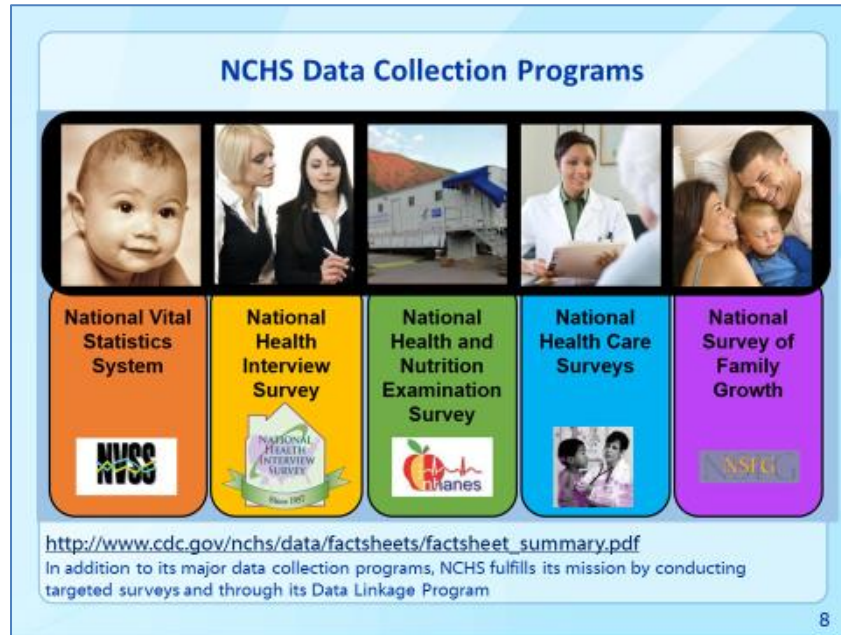
As a statistical agency, NCHS has been the nation's principal health statistics agency since 1960 authorized under 42 US Code § 242m General provisions respecting effectiveness, efficiency, and quality of health services:

- Sec. 306 of the Public Health Service Act: NCHS "shall conduct and support statistical and epidemiological activities for the purpose of improving the effectiveness, efficiency, and quality of health services in the United States."
- Mandated annual reporting to Congress and the president on health care costs and financing; health resources; utilization of health services; and health of the Nation's people.
- Section 308(d) of the Public Health Service Act (42 U.S.C. 242m) Governs consent, and use of information.

The NCHS Confidentiality Statute stipulates that no information, if an establishment or person supplying the information or described in it is identifiable, obtained in the course of activities undertaken or supported under section 304, 306, or 307 may be used for any purpose other than the purpose for which it was supplied unless such establishment or person has consented (as determined under regulations of the Secretary) to its use for such other purpose and in the case of information obtained in the course of health statistical or epidemiological activities under section 304 or 306, such information may not be published or released in other form if the particular establishment or person supplying the information or described in it is identifiable unless such establishment or person has consented (as determined under regulations of the Secretary) to its publication or release in other form.

In its statistical agency capacity, NCHS compiles and analyzes data for many national reporting efforts, many of them collaborative in nature in order to: 1) conduct national reporting (Health, United States, for example); 2) support Departmental and interdepartmental initiatives (Healthy People, Children's Forum, National Healthcare Quality and Disparities Report, for example); 3) explain contextual factors and explore social determinants; 4) improve relevance or timeliness; and 5) understand and improve quality of data. An example of NCHS's crosscutting methods work is a statistical brief on *Measuring Progress toward Target Attainment and the Elimination of Health Disparities in Healthy People 2020*.

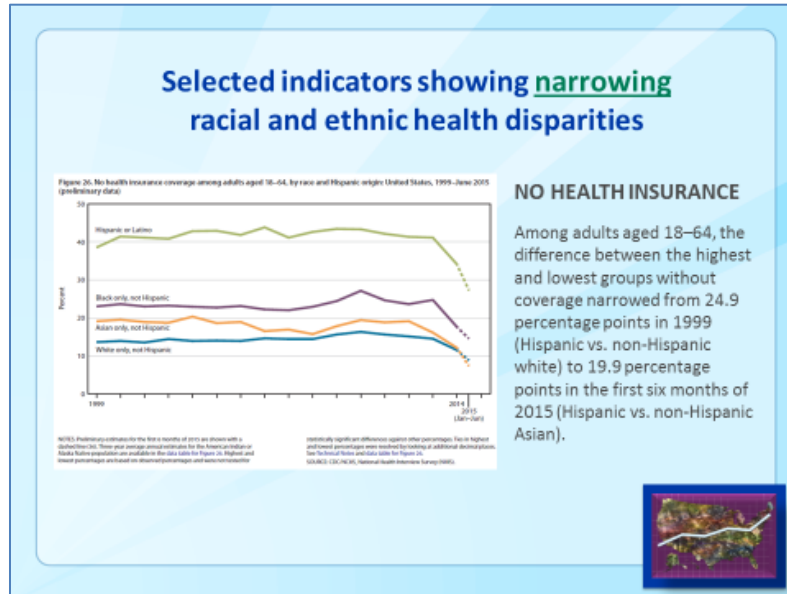
NCHS's data programs are pictured here:



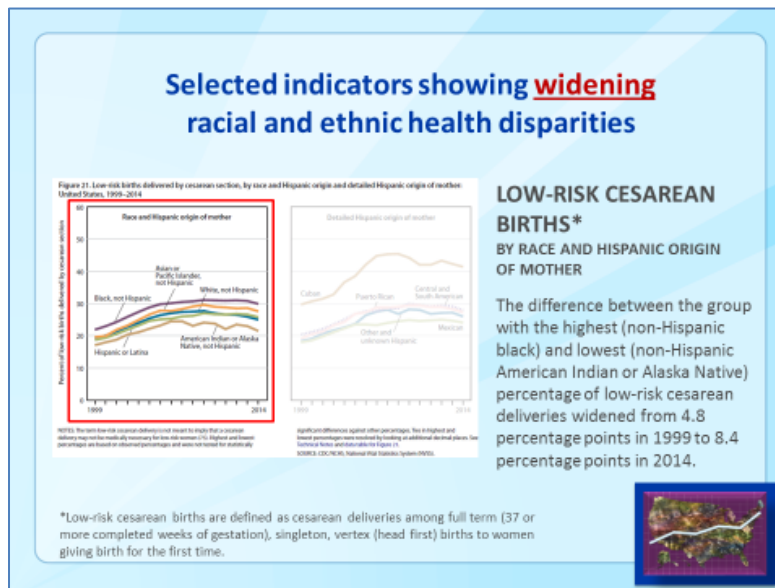
Health, United States was the impetus for the Heckler Report. The 1985 *Heckler Report* primarily reported black/white differences, given that data collection for minority groups was limited. Where the *Heckler Report* did present data on additional minority groups, it relied on non-national data. HHS defines a health disparity as a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Not all differences reflect disadvantage. For example, differences in the prevalence of chronic conditions between those over 65 and those younger than 65 would not be viewed as a disparity, but rather as a difference based on age. In the *Health, United States, 2015 Special Feature on Racial and Ethnic Health Disparities* the differences in the collection and reporting on race and ethnicity can be seen between the *Heckler Report* in 1985 and 2015. The 2015 report reexamines disparities by more detailed racial and ethnic groups.

In terms of how disparities are measured in *Health, United States*, there are many ways to measure differences between groups and changes in such difference over time. NCHS wanted to use a method that was straightforward and had been used in other federal reporting efforts. Therefore, they used one of three methods from Healthy People 2020 —the maximal rate difference or the absolute difference between the highest and lowest groups regardless of whether the rankings changed over the period. They were interested only in whether the overall disparity increased, decreased, or stayed the same. They used JoinPoint to determine whether the absolute difference between the highest and lowest observed groups significantly changed over the study period regardless of whether the highest and lowest groups changed. A majority of the graphs present trends between 1999–2014, as they wanted to compare changes over essentially the same time period.

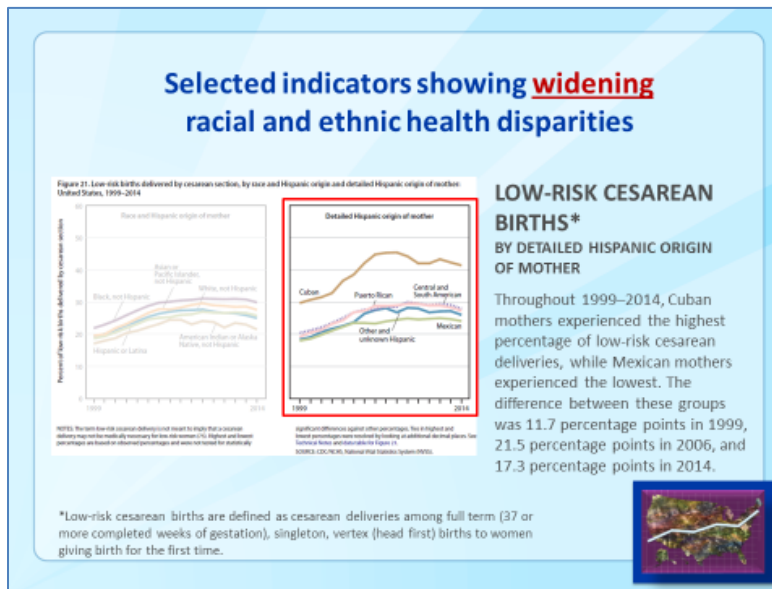
The following is an example of narrowing racial and ethnic health disparities based on preliminary data from the National Health Interview Survey (NHIS) for the first quarter of 2016. It shows the difference between the highest and lowest groups in the percentage of uninsured adults aged 18 through 64 years of age, (Hispanic vs. non-Hispanic Asian):



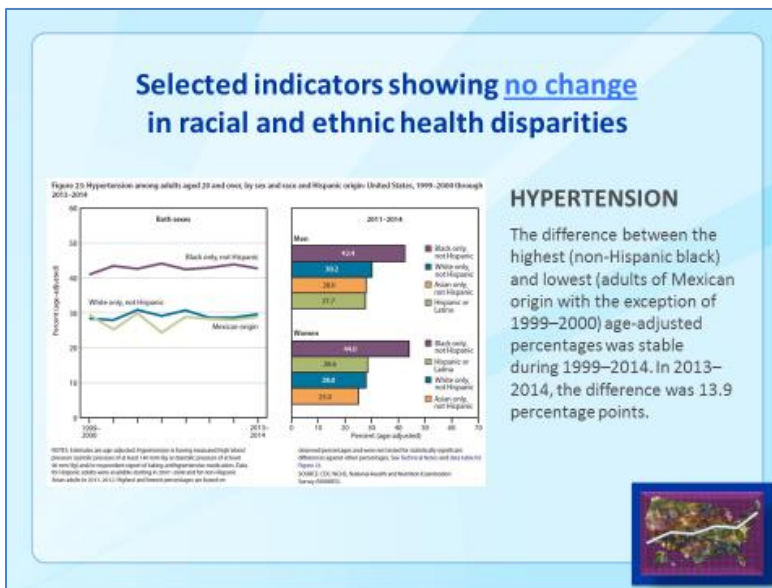
The graph on left hand side in the following example presents low-risk cesarean births by race and ethnicity. During 1999-2014, non-Hispanic black mothers experienced the highest percentage (about 3 in 10) of low-risk cesarean births among the five race/ethnicity groups and American Indian / Alaskan Indian mothers experienced the lowest (a little over 2 out of 10):



The graph on the right hand side in the examples below presents low-risk cesarean births by detailed Hispanic origin. Cuban mothers are the highest throughout (over 40% in 2014), with Mexican mothers the lowest (24.1% in 2014):



In the following example, there is a health measure with no change in disparity by race/ethnicity. These data are from the National Health and Nutrition Examination Survey (NHANES) on measured Hypertension among adults 20 and over and are age-adjusted:



On the left side of the panel above, there are age-adjusted percentages among non-Hispanic whites, non-Hispanic blacks, and Mexican origin adult. It has been only recently that NHANES reported on Hispanics as a group as opposed to only Mexicans. Non-Hispanic blacks had the highest percent of hypertension during 1999/2000–2013/2014, while with the exception of 1999–2000, Mexican had the lowest percentage with hypertension. For example, in 2013/2014 about 43% of non-Hispanic blacks

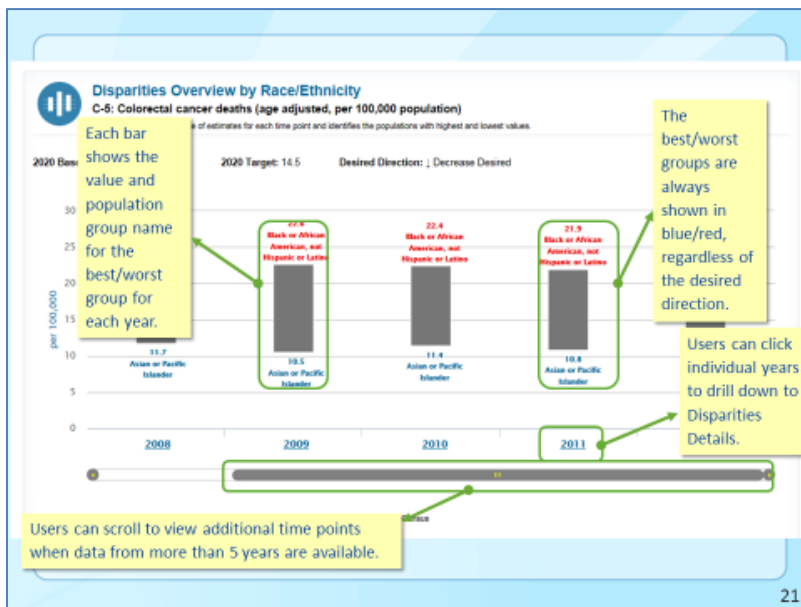
versus 28.8% of Mexicans had measured high blood pressure. On the right hand side are the current 4-year estimates of hypertension by race and Hispanic origin. Among men, the difference between black non-Hispanic and Hispanics was 14.4 percentage points. Among women, the difference between non-Hispanic black females and non-Hispanic Asian females was 19 percentage points.

Healthy People 2020 is a joint venture between Office of Disease Prevention and Health Promotion (ODPHP), NCHS, and Topic Area workgroups. The role of NCHS's Health Promotion Statistics Branch (HPSB) in Healthy People is to: 1) serve as Statistical Advisor to HHS and the Topic Area workgroups on health promotion data; 2) maintain a comprehensive database for all the Healthy People objectives; 3) research and develop methods for measuring the overarching goals of Healthy People (e.g., health disparities); and 4) create analytic and graphical presentations to display progress towards reaching the goals and objectives.

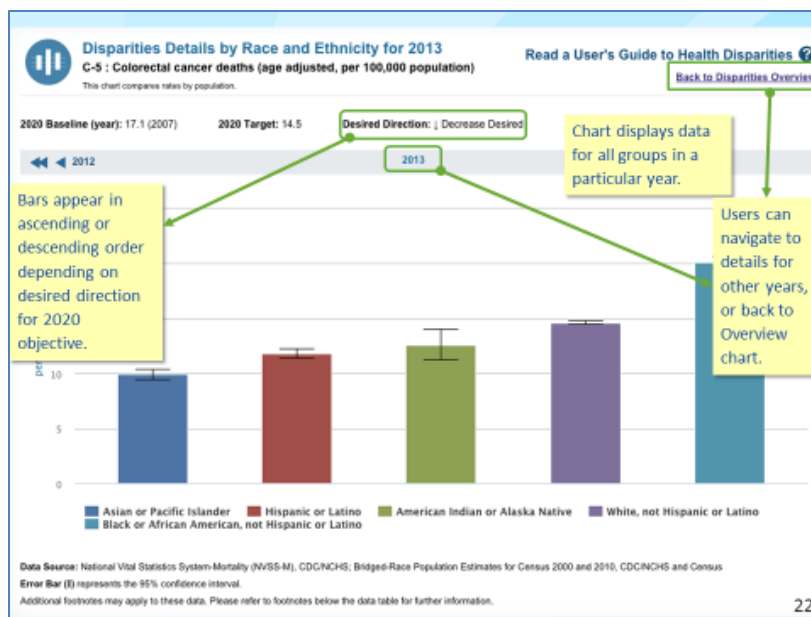
Mr. Rothwell shared one example of work they do to assess health disparities, the Disparities Tool. This tool was developed with funding, in part, from CDC's Office of Minority Health. A new data feature on HP.gov is the ability to look at where disparities exist for highlighted priority populations. This feature can be accessed from a specific objective page by clicking on the "Spotlight on Disparities" link:



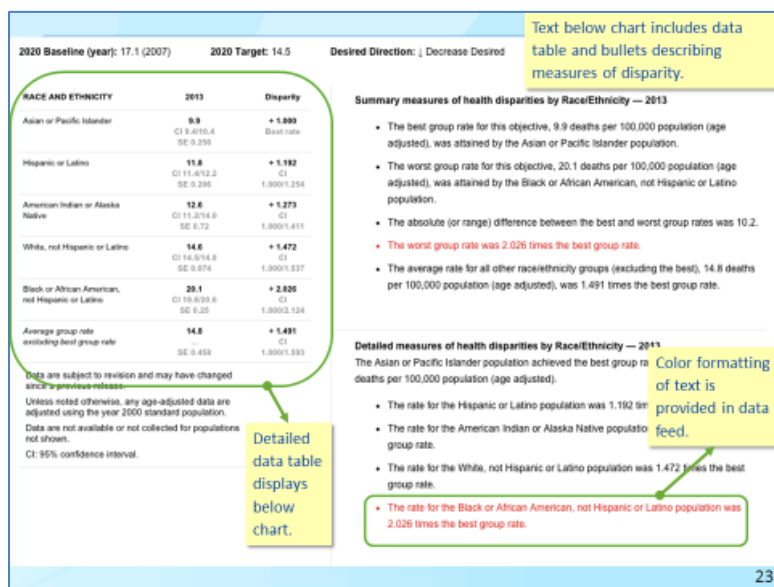
This chart displays the range of estimates for each time point and identifies the populations with the highest (red) and lowest (blue) values:



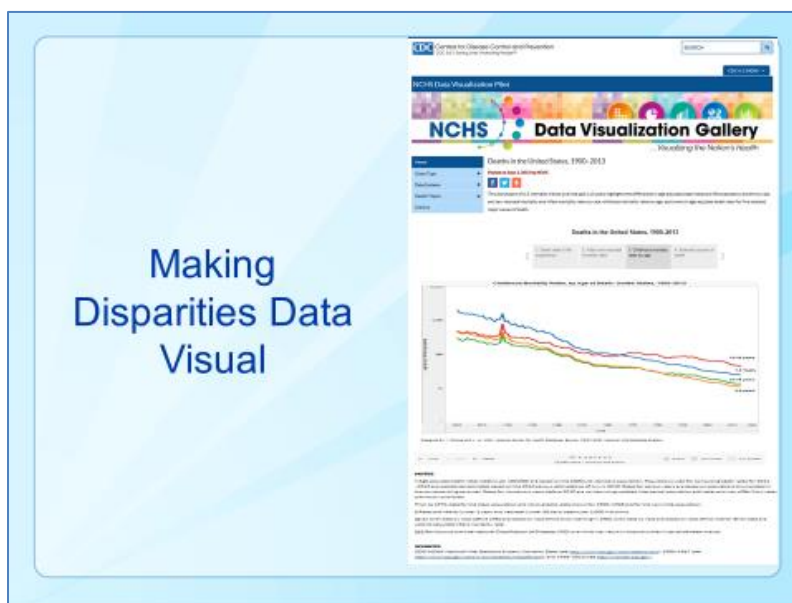
This chart compares rates by race/ethnicity for the year 2013:



The following illustrates the detailed data table displayed below the chart, the text below the chart that includes the data table and bullets describing measures of disparity, and the color formatting text is provided in the data feed:



Other NCHS efforts pertaining to disparities includes studies on methods and measures, research on health disparities, use of Data Briefs to make data more accessible, and making disparities data visual as shown in the following illustration:



Discussion Points

Pointing out that a lot of work has been done in terms of disaggregation, Dr. Ro asked why data are still being used that lump “Asian or Pacific Islander” together?

Mr. Rothwell replied that it is partly because of the small number of people who are in these groups, and people want them to rely on state-specific estimates. In addition, the cost of breaking that down to smaller groups would be very expensive.

Dr. Ro pointed out that the work that has happened through NCHS to have an oversampling of Asians for both NHIS and NHANES has been very much appreciated and they feel like major headway is being made. However, continuing to lump Asians with Pacific Islanders masks a huge disparity. Almost all data show that in Asians versus Pacific Islanders, the health outcomes are very different. Even within Asians, there are challenges with aggregated data. Particularly in those areas where there are two separate categories, it is something they are considering moving away from. Mr. Rothwell said that he agreed completely.

Dr. Richardson said it seemed like a continuation of the history of when the categories were just “white” and “non-white” and they threw the non-whites away because there were not enough of them to say anything. She emphasized the importance of getting this right in these public health datasets that many people depend upon for so many things. Of course, they are captive to what already has been done in the past and the way the data were collected at a certain time. However, her understanding was that the data are disaggregated when it comes to NCHS suggesting that this was a consolidation NCHS did rather than not knowing if respondents were Asian or Pacific Islander.

Mr. Rothwell responded that this was correct.

Dr. Richardson asked how much of this is driven by NCHS’s need to provide this [data] at various smaller geopolitical levels? She added, surely for the national data, there would be enough to disaggregate.

Mr. Rothwell confirmed that it is a sampling issue.

Dr. Ro said she appreciates the partnership with NCHS. NCHS has reached out to the Asian community, which has been a great model for other communities. The national Asian organizations are very aware of this when calling for data. It is her hope that continued efforts to partner with these national organizations and the community will help change that. Finding ways to have data on the health of the nation is increasingly challenging.

Mr. Rothwell emphasized that the attitude toward government in general right now is not helping them from a survey perspective. Even local governments in some states are not supportive. This has never happened before in the history of NCHS. He thinks they need to have an advertisement program to let states know how important these surveys are for health data. They had a response rate in a recent NHANES site of only 33% - a horrendous response rate for NCHS. This was a site where the county folks did not want to support them.

Dr. Ross emphasized that there must be a resolution on this issue going forward. There were times when there were great NHANES cohorts that had grouped years, which provided significant data. If it is not a problem with formatting, he did not think it would be unreasonable to disaggregate the Asian data and lump according to years. At least that would provide some way of disaggregating those two groups.

Mr. Rothwell indicate that whenever they publish something, they have to make the data available. Others can do a deeper dive into something that they may have glossed over.

Dr. Lichtveld said that Mr. Rothwell probably knew that one of the reasons the HDS asked him to share some time with them is because they care deeply about how data are collected, because how data are collected will impact the ability to do something about health disparities. She asked if he could share the decision tree of how data fields are decided upon and implemented for any data that are collected?

Mr. Rothwell replied that in terms of NCHS surveys, the individual data are available. They basically determine what age groups, racial groups, et cetera make sense. Sometimes, outside groups comment on NCHS's reports and sometimes there is disagreement. For example, NIH will publish some cancer rates where they break groups out differently. But, this is fine.

Dr. Lichtveld clarified that her question pertained to way before getting to the data, and that she was asking how decisions are made about what variables would be collected in the first place and how NCHS makes decisions about collecting this age group versus that age group, this part of the Asian group, these Hispanics and not those Hispanics. The idea is to inform data collection by beginning to define the data fields.

Mr. Rothwell responded that they collect race / ethnicity data based on standards. There is a new standard out on how data are collected, and NCHS has to follow those standards. When they are collecting information in their surveys, they may discover that the survey is taking too long and they need to cut it down by a certain percentage. For example, the NHIS is too long and must be cut down by at least 30%. They are doing this by involving all of the users of their data, which is done through *Federal Register* notification to obtain feedback from others. They do not make these decisions on their own. They also have listservs that can be used to send information to people who utilize their data. They work with CDC and NIH to determine what they are or are not collecting. They give people a chance to add data sources. Within CDC at least, NCHS receives more outside funding than any other center, which is both good and bad. They do not have the money to support this independently. CDC and NIH supplement NCHS's budget so that they can have this actual sample size. This is good, but if those agencies have funding problems, it impacts NCHS.

Ms. Wilson asked who determines what the data collection elements will be for the CDC-specific surveillance programs. Based on an analysis of surveillance systems they heard about the previous day in the SHE Forum about CDC's 125 different systems, some of them collect race and ethnicity, but not very granularly. They do not collect primary language and are not great on collecting country of birth and immigration status. Since about 2013, there has been discussion about collecting gender identity. However, she expressed concern about the potential for loss of data elements in the parsing down of the NHANES survey. She asked who they should go to for discussions about getting elements added to these surveillance programs. It is not possible to determine disparities if the data are not being collected.

Mr. Rothwell replied that Chesley Richards has been given the responsibility for ensuring that all of CDC's surveillance systems are collecting data in a similar manner. CDC has been trying to do this for years, and now the effort has moved further along than he has ever seen.

Dr. Ro emphasized that the HDS cares passionately about data, and one of the topics they have been talking a lot about is SDOH. She was pleased to see that Mr. Rothwell and other leadership from other data collecting agencies are in conversations. As public health moves forward, it is important to work at the intersections of health and housing, health and education, health and transportation, et cetera. She asked whether there is work underway at NCHS to try to link data, or how they are addressing SDOH.

Mr. Rothwell replied that NCHS can always help health by collecting data on SDOH. Health is determined by a variety of social issues and the environments in which people live. NCHS has done some work with the Department of Housing and Urban Development (HUD) to link NHIS, NHANES, and vital statistics to health data and who receives what types of support, and how that impacts health status. Technology now makes it possible to combine a variety of datasets, such as Department of Justice (DOJ), HUD, IRS, Social Security, and others and to analyze these data in a much more granular and broader way. There are numerous protections to safeguard against identification of individuals, but this is also a barrier in terms of collecting and analyzing data. Legislation needs to be assessed and modified in order to broaden analytical capabilities. Mr. Rothwell hopes that there are some legislation changes that would require NCHS and similar agencies to do business with others.

Dr. Richardson recalled that during another conference she attended at CDC, there was a lot of discussion about the language questions that are included in NHANES and NHIS and how to ask about English proficiency and preferred language. Apparently, the questions are different and not what is considered best practices amongst scholars in the 21st Century. She asked how to get that changed or who they need to speak with or influence to address these concerns. These are surveys that CDC owns, and as a subcommittee to the ACD, the HDS wants to understand who to discuss this with because it needs to be changed. She said she understood all of these issues pertaining to changing questions and losing the ability to compare to previous years' data and so on; however, there is a balancing act. The argument that "we've been doing it wrong for 20 years, but we have to keep doing it the wrong way" is not something she is particularly responsive to.

Mr. Rothwell replied that within the NCHS surveys specifically, that would be him. Otherwise, it would be the individual Directors for each of the surveys. NCHS has a questionnaire design lab that tests every single question that they have in their surveys, and it is one of the most rigorous he knows of. This also may be true for the rest of CDC. There is what they think is a right way and wrong way to ask questions.

Dr. Richardson stressed that it is not so much the *how* as the *what*. She knows that the psychometrics are rigorously done, but this is the conversation she hopes they can pursue and perhaps bring together some of the academic experts who take issue with what currently is in these surveys, particularly with regard to the issue of language. A source of data that has not been used traditionally very much by public health but really is emerging as a potentially hugely informative resource are electronic health records (EHRs), which include detailed granular information about individuals that is being accumulated in various practice sites. Some of it is accumulating in the federal government in places like the Centers for Medicare and Medicaid Services (CMS) claims data. She wondered if any thought had been given to integrating those data more into the NCHS data integration efforts.

Mr. Rothwell replied that there has been discussion about integrating data from EHRs into NCHS's data integration efforts. In the next 3 to 4 years, the healthcare surveys are likely to go completely to EHRs. This is good and bad. There will be 10s of millions if not 100s of millions of health records. The problem regards standards. The worst problem is that the demographic information on medical records has never been very strong. The potential is just fantastic. Due to Meaningful Use, instead of having to cajole their way in to abstract records, offices are willing to offer NCHS anything they have since NCHS can protect the records.

Dr. Richardson agreed with the potential and the many challenges. As a practicing physician, she knows a lot about how data gets into EHRs, and it does not even begin to approach the kind of standards that exist in public health surveys. Therefore, she cautioned him about not phasing out the healthcare surveys too soon until a better job has been done of improving the quality of the data from EHRs. That is going to take some time. Nevertheless, this is promising. ACD has a large group assessing the public health-healthcare interface, and the issue of having clinical data inform public health is a major issue that that group focused on. On behalf of the committee, Dr. Richardson thanked Mr. Rothwell for his time and presentation. As he heard, there is tremendous interest and passion among the HDS members about data. They are very appreciative of the ways in which NCHS has informed the health equity initiative and monitoring of health disparities. They would like to continue to speak to and work with Mr. Rothwell as they try to make it even better, because there are some issues on which progress could be made.

Mr. Rothwell noted that the Healthy People objectives have grown over the years. There are now over 1200 being monitored. It is easy to get lost in all of the information. They need to hone in on those important outcomes to make sure they get sufficient details relevant to demographics so that they can look at where the real health disparities are.

Dr. Richardson replied that there are probably lots of thoughts on what are *the* most important areas. This goes back to the same issue of data sources. Still, for some of the Healthy People objectives, the data sources do not provide the granularity one would hope for to assess some of the issues that might, indeed be very relevant. There are some important indicators that probably are not even part of Healthy People 2020 even with its huge number of indicators. This is a conversation that will continue.

MASO Update on the FACA Nomination Process

Ms. Tracie Strength (ACD Committee Manager) discussed changes in the way members of the HDS are solicited. She reported that HDS has 5 members who will be rotating off at the end of June 2017 (Willie Horner-Johnson, Anthony Iton, Marguerite Ro, Will Ross, and Hector Vargas). These members have served two consecutive terms back-to-back, which is the limit permitted on one subcommittee. In the past, the solicitation has been submitted to the ACD, which is the parent committee to the HDS. The suggestions for new HDS members have been made by ACD members, other DFOs, chairs, et cetera. This year, after speaking with Carmen Villar, who is the DFO for the ACD, they decided they would publish a *Federal Register Notice (FRN)*. This is the first time this has been done for a subcommittee. It is allowable and MASO is very excited about it because it never has been done before. In doing so, the *FRN* closed on September 30, 2016. MASO received 14 nominees to backfill the departing 5 HDS members. If they provided a recommendation letter, she printed that out along with their CV. She provided that to the HDS support person, Ms. Sheneta Green. At this point, the HDS DFO must review the nominations. Once she reviews them and selects her top 5, they will be returned to MASO and a

packet will be prepared for the ACD DFO for her to review and approve. Once approved, the nomination package will be started.

Discussion Points

Dr. Richardson said that she very much liked the idea of publishing an FRN to allow people who are interested to identify themselves, but she asked whether they were limited only to these 14.

Ms. Tracie Strength replied that HDS would not be restricted to only these 14 and could reach out to anyone they wished in addition to reviewing the people who self-nominated.

Dr. Richardson pointed out that there are sometimes particular content or methodologic areas of expertise that they feel would benefit HDS and be an asset to the subcommittee.

Ms. Tracie Strength noted that MASO just finished its review of ACD nominees. Over 100 nominations were presented for only 7 positions that had to be backfilled. They reviewed all submissions through the *FRN*, and reached out to individuals they knew. If the HDS wishes to recommend someone, they would have to provide a CV and contact information for that individual. She indicated that the term is 2 years, which can be extended to 4 years. Members can cycle off after 4 years and return after a specific length of time. A request can be made to remain on the HDS longer, but it may not get approved. A justification letter must be submitted, which will be reviewed by the DFO and approved by MASO. The terms are staggered so that everyone does not rotate off simultaneously.

Dr. Lichtveld pointed out that the 2-year term limit makes it difficult to maintain continuity. In many organizations, the term is 3 years. Others agreed.

Dr. Richardson pointed out that when she first joined the committee as Chair, there were a large number of vacancies. This included vacancies that had not been filled for some time due to people cycling off and / or leaving, so there was a lot of activity focused on reconstituting the committee. She wondered whether that would be considered an appropriate justification to not have all 5 members rotate off at the same time.

Ms. Tracie Strength said that one thing to consider is that they can continue to sit on the committee for another 180 days after their expiration.

Dr. Liburd requested additional information about the total number of slots assigned to the HDS. In addition to understanding how many slots are vacant in addition to the 5 who are rotating off, the total number affects quorum.

Ms. Tracie Strength will review the charter to be certain of the total number of slots. To achieve quorum, they have to have half plus one of the members present. She will confirm the specific requirements and member terms for the HDS. She noted that they do not need to rush on the nominations because they have plenty of time, and the HDS nomination package stays in-house and does not have to go to HHS.

STLT SDOH Think Tank Collaboration

John Auerbach, MBA (Acting Director, OSTLTS; Associate Director for Policy, CDC; STLT Subcommittee DFO) started by saying that the State, Tribal, Local, and Territorial (STLT) Subcommittee relates to OSTLTS's work with its partners in each of those areas. The STLT Subcommittee has a long history of very close partnership with HDS, and OSTLTS and the STLT Subcommittee take the partnership with HDS very seriously. Before he came to CDC 2 years ago, he was on the subcommittee and before he met Dr. Liburd, he heard her voice on many of those committee calls because so much of the work of the STLT SDOH Think Tank overlaps very closely with the work of HDS. He pointed out that the person who deserves the most credit for the functioning of the STLT Subcommittee is Judy Lipshutz, who is a Public Health Analyst for OSTLTS.

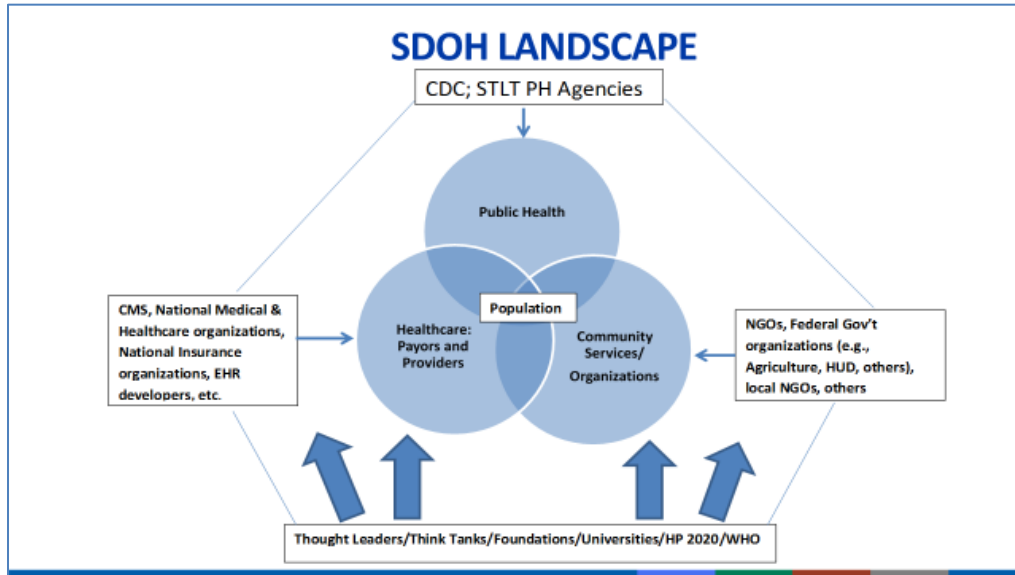
In terms of background, the STLT Subcommittee has found it helpful to have three different subunits that are assigned specific and concrete tasks related to topics that have been identified by the subcommittee members as being critical. These are referred to as "Think Tanks," which is a term that is unofficial and frees up those entities that have non-subcommittee members to participate in a less strictly regulated manner. Nothing gets done until they present a recommendation to the STLT Subcommittee. The STLT Subcommittee is then in a position to deliberate officially. The three Think Tanks are: Public Health Surveillance Think Tank, Public Health Finance Think Tank, and SDOH Think Tank—the focus of this session.

The SDOH Think Tank is comprised of the following members:

- Jose Montero, MD, MHCDS (Chairperson): Cheshire Medical Center / Dartmouth-Hitchcock Keene
- Jay Bhatt, DO, MPH, MPA: Illinois Hospital Association
- Ed Ehlinger, MD, MPH: Minnesota Department of Health
- Jonathan Fielding, MD, MPH: UCLA School of Public Health
- Rishi Manchanda, MD, MPH: Health Begins (Los Angeles)
- Julie Morita, MD: Chicago Department of Health
- Rev. Kenneth Robinson, MD: United Way of the Mid-South
- Lauren Smith, MD, MPH: FSG Reimaging Social Change (Massachusetts)
- Umair Shah, MD, MPH: Harris County Health Department (Texas)

The goal was to try to have strong participation from each one of the entities in the STLT Subcommittee name. The Chair of the Think Tank, Dr. Jose Montero, was recently selected to become the Director of OSTLTS. He will leave the Think Tank as Chair once he begins his work as Director of OSTLTS.

The STLT Subcommittee and Think Tank are not thinking about SDOH in the largest landscape. Instead, they are thinking about it in terms of the specific activities that CDC can do. The mission of this group is to think about what they can concretely and specifically do to advance this type of work. Doing so requires working with a number of sectors and organizations, including federal organizations that represent the broad sector of activities and OSTLTS partners, as illustrated by the following graphic:



The purpose of the SDOH Think Tank is to enhance the capacity of CDC, state, tribal, local, and territorial public health jurisdictions, and health system partners to identify and address SDOH inequities to improve population health. The goals for SDOH at CDC are as follows:

Where We Want to Be (long-term)

Social norm change where SDOH are part of the fabric of CDC programs, policy, and research at the level that is appropriate. Given the complexity of CDC and the hundred different programmatic areas, this will take some time to get into everyone's "DNA," but they are working toward this.

Best Way to Get There (medium-term)

Work to ensure CDC initiatives incorporate SDOH using a consistent framework with consensus-based definitions.

Start with Low-Hanging Fruit (short-term)

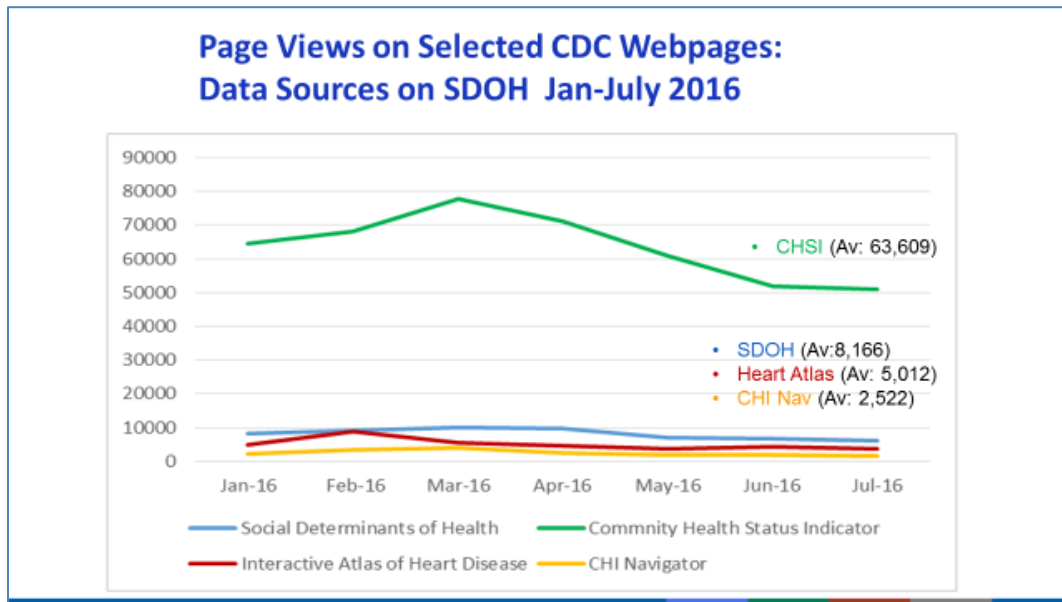
Help health departments access and analyze non-health data sources for better understanding of the full context of health conditions affecting population health. The members of the SDOH Think Tank have encouraged STLT / OSTLTS to begin to pay a lot of attention to data sources, because one issue holding back OSTLTS partners is simply having the specific data sources that allow them to consider the SDOH in a meaningful way. They also pointed out that CDC is very uneven in terms of its consideration of SDOH. It would be helpful to have a consistent platform that CDC uses, as well as access to resources. Some of the initial work has focused on this area.

As a reminder, the SDOH Think Tank and STLT Subcommittee were initiated in February 2014. They have tried to be very concrete and specific in terms of making recommendations first to the STLT Subcommittee, and then from the STLT Subcommittee to the ACD. The STLT Subcommittee planned to make two recommendations to ACD the next day on October 20, 2016.

In terms of some of the outcomes that have come from the direction of the SDOH Think Tank members and the STLT Subcommittee to get things done, one early achievement was working in partnership with Dr. Liburd, OADP, and OSTLTS to develop for the first time a [SDOH website](#) with data elements. The site lists existing sources of data on SDOH, and provides guidance to help understand which ones are stronger, which ones are more up-to-date, and which ones offer a more granular versus a county or city level. They wanted to be able to say to everyone that there is a source that CDC recommends as they are exploring SDOH.

They also have worked to explain to all of CDC's partners at all levels inside and outside of public health why SDOH are an integral part of core public health. Ms. Judy Lipshutz developed a tool known as: [Ten Essential Public Health Services and How They Can Include Addressing Social Determinants of Health Inequities](#). The SDOH Think Tank members provided feedback on the tool. The tool goes through the 10 essential services and explains how each one of those is very much related to SDOH. Reinforcing that SDOH are not new or unrelated to core public health has increased the comfort level of STLT leaders in adopting SDOH in their public health practice. This tool has been well-received by OSTLTS' partners.

In addition to the SDOH website, there are other SDOH-related websites as well that have been developed since 2014 when the SDOH Think Tank and STLT Subcommittee began. These include a [Community Health Status Indicators \(CHSI\)](#) tool, which is a website where the specifics of a community can be entered and provide a profile of both health and SDOH data. Each profile includes key indicators of health outcomes, which describes the population health status of a county and factors that have the potential to influence health outcomes, such as healthcare access and quality, health behaviors, social factors, and the physical environment. The following chart shows utilization of the CHSI. They are very pleased the CHSI, represented by the green line, shows that there has been pretty phenomenal utilization of this tool, and they are happy with utilization of the other sites as well:



The latest development in terms of tools that help OSTLTS partners is the [Health Impact in 5 Years \(HI-5\)](#) initiative. This was an attempt to do what CDC does very well, which is look at the evidence base. They looked at the evidence base in the *Community Guide*, RWJF, and published literature. They wanted to be able to offer a tool to OSTLTS' partners regarding policies that were related to laws, regulations, or changes at the city, county, state, or federal levels that they could say definitively improved health in 5 years or less. They set the bar high in that the HI-5 initiative highlights non-clinical, community-wide approaches that have evidence reporting: 1) positive health impacts, 2) results within five years, and 3) cost-effectiveness and / or cost savings over the lifetime of the population or earlier. The focus was to provide evidence that some of what they were saying works, and they were very pleased to see in this analysis that there were 14 interventions that met those very high criteria. Of the 14, 6 of the interventions turned out to be very much related to SDOH:

14 Evidence-Based, Community-Wide Interventions

<i>Address the Social Determinants of Health</i>	<i>Change the Context: Making Healthy Choice the Easy Choice</i>
<ul style="list-style-type: none">• Early Childhood Education• Clean Diesel Bus Fleets• Public Transportation System Introduction or Expansion• Home Improvement Loans and Grants• Earned Income Tax Credits• Water Fluoridation	<ul style="list-style-type: none">• School-Based Programs to Increase Physical Activity• School-Based Violence Prevention• Safe Routes to School (SRTS)• Motorcycle Injury Prevention• Tobacco Control Interventions• Access to Clean Syringes• Pricing Strategies for Alcohol Products• Multi-Component Worksite Obesity Prevention



Notably, the 6 interventions related to SDOH included work outside of the healthcare sector and socioeconomic status (SES) indicators such as low-income tax credits and loans to improve housing. There are other interventions that also probably work, they just have not been studied yet. For example, people have asked why income levels or minimum wage are not listed. These simply have not been studied to show definitively that they work.

Additional selected recent CDC SDOH resources include the following:

- Special supplement in the [Journal of Public Health Management & Practice](#) *Advancing the Science and Practice of Health Equity*
- [Health Equity Section](#) of Community Guide
- Community Health Improvement [\(CHI\) Navigator](#) HP 2020 Social Determinants of Health [Interventions & Resources](#)

Going forward, the STLT Subcommittee framework is committed to:

- Sustaining impactful PH departments into the future
 - engage in cross-cutting collaboration
 - include environmental, policy, and system-level actions
 - take actions that impact social and structural determinants of health inequities
 - Long term CDC goal: *Achieve a social norm change where social/structural determinants are part of the fabric of CDC programs, policy, and research at the level that is appropriate*
- Health Officer as Chief Health Strategist at STLT levels
- Supportive infrastructure within CDC for public health departments (i.e., OSTLTS)

Proposed Recommendations 5 and 6 that the STLT Subcommittee will make to the ACD during its October 20, 2016 are:

Proposed Recommendation 5: Maintain and Improve CDC Support to Social/Structural Determinants of Health (SDOH) Tools

Ensure that SDOH-supportive resources, such as CHSI, SDOH website, and HI5 are maintained, updated, and promoted as necessary on an ongoing and long-term basis.

The STLT Subcommittee will indicate to the ACD that this recommendation is in support of and complimentary to the HDS recommendation adopted in April 2014 to “Build community capacity to implement, evaluate, and sustain programs and policies that promote health equity, especially in communities at highest risk.”

Proposed Recommendation 6: Improve Competence / Functional Capacity of STLT PH to Address SDOH Inequities

CDC should:

- Promote a public health framework with a broad and intentional SDOH perspective.
- Explore ways to improve the capacity of public health agencies to address social determinants.
- Enhance the PH workforce’s capacity to promote and incorporate work on SDOH as a core activity.

Mr. Auerbach clarified that these recommendations were number 5 and 6 because they will be combined with recommendations from the other Think Tanks. He also noted that they cannot make recommendations that pertain to funding, but they wanted to ensure support for what already exists, particularly if CDC enters a transition period.

Discussion Points

In response to a request for further information about the makeup of the Think Tanks, Mr. Auerbach replied that the Think Tank Chair has to be an STLT Subcommittee member. While STLT Subcommittee members are encouraged to participate in Think Tanks, the Think Tank structure permits the flexibility of including non-subcommittee experts. The STLT Subcommittee felt that those experts were needed in its work, and liked the idea of this flexibility.

Dr. Richardson pointed out that some people do not want to go through the process it takes to get on a federal advisory committee, but are interested in helping. They had a long conversation about what could be done to avoid having to meet all of those requirements, including the notice in the *Federal Register* about meetings, et cetera. Certainly, that model is open to the HDS. The HDS has not utilized the Workgroup or Think Tank model thus far, given that they have tried to focus on finding its own way before convening outside individuals. However, they are open to it.

Ms. Thompson asked whether the intent of the SDOH was to focus specifically on the needs of Native American populations.

Dr. Richardson replied that it includes all state, Tribal, local, and territorial departments of health in all of the geopolitical manifestations.

Ms. Thompson said her question still would be similar in that she wondered to what degree the particular needs and interests of native populations are being met, or if it is the assumption that everybody benefits from having these broad priorities.

Mr. Auerbach replied that the goal is to determine both the commonalities and differences. Tribal and territorial representatives have been helpful in terms of adding to our understanding of the distinct and different needs of the populations they represent. It is much more common that they understand aspects of state and local public health, and they have had very lively discussions where people have distinguished between the way that any particular activity might play itself out in a Tribal land or in a territory and how to think about these differences.

Ms. Thompson asked whether there was a list of the tools that Mr. Auerbach mentioned in his discussion of effective tools.

Mr. Auerbach clarified that they call the website a tool. Within the website, there are different data sources. The tool just makes them easier to access.

Dr. Ro said she thought the SDOH and the HDS's work on health equity are really where the intersections are. She expressed her hope that everyone had looked at the California Endowment's Building Healthy Communities (BHC) Social Determinants of Equity framework. She worries that SDOH and health equity continue to be piecemealed separately. She worries that in the framework, if equity is not seen there, it is a huge missed opportunity. Second, she said she was happy that in the STLT Subcommittee there is a Public Health Finance Think Tank, because consideration is given to representing local public health. However, she worries about the role of Chief Health Strategist being seen as convener and not also resourcing this enough to have the expertise to actually be the Chief Health Strategist and not just the convener. There is a huge body of work in terms of workforce training, and she thinks they have to be more proactive about this. Third, she said she was happy to see

the HI-5 work. Even though some of the HI-5 interventions appear to be related to Dr. Frieden's 6/18 Initiative, the 6/18 Initiative does not include having SDOH be a Winnable Battle. Even if it is aspirational, she would love to see SDOH reflected in Dr. Frieden's priorities.

Mr. Auerbach responded that there has never been a STLT Subcommittee meeting that has not included a strong and meaningful discussion about the critical importance of addressing health equity across all three Think Tanks. They have heard a number of presentations on the connection between SDOH and health equity as well. He thought that Dr. Ro was right to raise this issue and that a reminder that SDOH is part of the core activities should appear in any presentation. The STLT Subcommittee does not think that SDOH can be part of the DNA without health equity being part of the DNA and approach. That connection is unbreakable. They have heard a lot about financing as well. People have said to them that if they are saying to local and state health departments and officials that it is important to work across sectors, people need resources to do that. It is about much more than convening. It also is about engaging with other sectors, getting to know and respect them, know their roles, attend their meetings, et cetera. Doing this is time-consuming and does not fit into a categorical funding approach that is disease-specific because it is not about a disease. There has been a lot of feedback for CDC funding that permits greater flexibility and provides attention to infrastructure at the local and state levels.

Dr. Ro emphasized that the HDS is very heavily invested in measurement. There is a difference between monitoring and setting benchmarks, or setting goals and outcomes that they would like to see in health equity. This is where she feels like they "drop the ball," because no one is truly held accountable for closing the gap. SDOH and health equity are slightly different frames, but they should not default to saying just one or the other.

Dr. Ross said he was looking at the programs that Mr. Auerbach outlined and reconciled those with the 5 recommendations made by the HDS. One of the HDS's recommendations that was very consistent with the STLT Subcommittee's recommendation was to "build community capacity to implement, evaluate, and sustain programs and policies that promote health equity, especially in communities at highest risk." Dr. Ross read the STLT recommendation which states, "Communities need technical assistance in how to address the SDOH, how to improve health literacy and cultural competence within the public health workforce, and how to sustain health equity programs when federal funding ends." In terms of the issue pertaining to federal funding ending, while it is not within the purview of subcommittees to provide funding or talk about extending funding, all of the programs that Mr. Auerbach listed as being effective had significant sustained funding beyond 5 to 7 years and they were able to enhance community capacity because they had this funding. Outside of other things such as accreditation standards for public health departments so that they can engage in community capacity-building, it was not clear to Dr. Ross how it would be possible to achieve the recommendations of the HDS and STLT Subcommittee to have community capacity without funding.

Mr. Auerbach said that the STLT Subcommittee has contemplated this mainly in terms of CDC and what CDC can do differently in terms of its funding approaches that would improve the likelihood of continued support reaching the right organizations and agencies. They also have talked about the importance of looking where there may be opportunities for other funding as well and thinking about ways to blend funding sources, and making it easier for CDC funding to be blended and more flexibly used in relation to other funding. They have discussed thinking about ways of shifting the responsibility of paying for certain things that are paid for by public health to the insurance sector. The STLT Subcommittee would welcome any additional suggestions from the HDS.

Dr. Ross stressed that his suggestion was to clearly state in their recommendations that they recognize achieving this recommendation will require extended financial support, and the need for financial support crosses all sectors. While he knows that they do not have a magic box of money to do this, Dr. Ross believes it would be Pollyannaish to not state that [lack of financial support] is a major limitation.

Mr. Auerbach replied that this is consistent with what the Public Health Finance Think Tank has attempted to incorporate into its series of recommendations. The Public Health Finance Think Tank has been acknowledging what Dr. Ross was saying and pushing them to think about whether there is something that can be done differently at CDC that might make this easier. He suggested that it would be helpful for the STLT Subcommittee members if Dr. Ross wrote down the language he would suggest. They want HDS' feedback as a fellow subcommittee. As mentioned earlier, they work closely with Dr. Liburd and HDS as partners in terms of addressing many of the same issues. They really would appreciate any feedback the HDS would like to provide about things to consider, things that they have missed, and things that the two subcommittees should do jointly. The STLT Subcommittee is totally open to HDS's guidance and recommendations.

Dr. Lichtveld asked whether all of the tools are interactive, and whether a visitor could tell CDC "I would like to have X dataset or X data point" and indicate when something is missing.

Mr. Auerbach replied that all of the tools are not interactive. Some of them simply link to articles or data sources. The CHSI does allow one to tailor reports to a specific community. He did not think that CDC had a mechanism through its websites for a visitor to ask for X dataset or data point or indicate that something is missing.

Ms. Lipshutz clarified that there were a number of websites listed, but there are more sections: data, programs, guidance, and policies. They are all different and some of them do have feedback mechanisms.

Mr. Auerbach recognized that Dr. Lichtveld was asking to make it easier to provide input, and perhaps this could be included on the Home Page. If it was another CIOs site, OTSLTS could call them. He indicated that they would look into this great suggestion.

Dr. Lichtveld noted that on Essential Service #8, assure competent public and personal health care workforce, the term "determinants of health inequity" was used. She said that while she liked that they used "inequity" deliberately, her recommendation would be to call it out [define it], because of the content.

Dr. Richardson said she thought that might be Healthy People 2020 terminology. She asked whether there were any other suggestions for collaborations with the STLT Subcommittee.

Ms. Thompson said she was curious to know whether the STLT Subcommittee had outlined the next phase / top priorities for moving SDOH forward.

Mr. Auerbach replied that the SDOH Think Tank felt that with the transition of the Administration, they were placing most of their emphasis on not losing ground and making sure they get through the transition. These are somewhat odd recommendations because they basically say "keep doing what we've been doing." There is a lot of interest in ensuring that they do this. They are involved in a pretty full discussion about what the next steps would be. There has been a focus on concrete and specific

outcomes with regard to following up on training needs, where the funding and resources would be to implement what they have said is important to do. Beyond that, they have not set forth any specifics.

Dr. Ro asked Mr. Auerbach to look forward to the next couple of years, whether it be at CDC or beyond, and share what he saw as the biggest opportunities they should be paying attention to in order to move health equity forward and an approach to address the SDOH.

In terms of his personal opinion, Mr. Auerbach said he thought the opportunities in terms of building stronger linkages between the healthcare and public sectors are rich. There are now 20 million more people with health insurance who did not have it before. Disproportionately, they are folks who have not had access to good care and often are low-income. Relatedly, the healthcare and insurance sectors are embracing the concept of population health and health equity in a way that has not been true before. Although there is a lot of potential in the healthcare, insurance, and public health sectors, unless they focus on how to take advantage of this potential, it will be a moment in time because there needs to be very specific ways to move ahead. First of all, it would be important to develop a set of action steps that they believe to be the highest priority, and reasonable, in terms of building linkages. There is a growing recognition in the public health arena that they must work across sectors and think “outside the box.” This involves changing the conditions in peoples’ lives. A part of this is explicitly naming racism, discrimination, poverty, and other real issues that often are barriers to good health. Public health can say that those things matter, but then often not know what to do about it. There is an opportunity to move concretely to action.

Dr. Richardson noted that earlier they had a presentation from Mr. Rothwell at NCHS, and it seemed to her that one of the themes to making SDOH and the path to health equity real lies in the issue of data. She was pleased to learn that Mr. Rothwell attends monthly meetings with the statistical directors of 12 other [federal] agencies. While she does not know what they talk about every month, she would like to get them in a conversation about how they could start linking datasets, understanding what each agency has and how it could inform the things that they care about. Related to this, Mr. Rothwell noted that being able to freely exchange data across federal agencies might require some change in the authorizing legislation. Dr. Richardson said, ‘that is fine. HDS can take that on.’ She has changed the law twice in her state during her career already, and she would like to do it on a national level. Understanding how these datasets could be used to inform each other and monitor and track the SDOHs and their impacts on health seemed to be one of those opportunities. Recognizing that this would be a major undertaking, she suggested that perhaps the HDS and STLT Subcommittee could think about this together and perhaps they could find a friendly partner.

Dr. Ro indicated that the White House is very friendly to this idea right now. They are doing this with law enforcement and health.

Mr. Auerbach pointed out that numerous transition documents are being written. He will share the ones he knows of or has been a part of with Dr. Liburd. There is one, for example, that was developed with the RWJF funding to assess the role that HHS could play in terms of addressing some of these issues and incorporating all of the departments. It spoke to the question of: At what governmental level do you need someone to convene the departments so that you can actually get buy-in from those departments? In some ways it was responding to the difficulties of trying to accomplish what Dr. Richardson was suggesting on a voluntary basis agency by agency. Folks have tried this with support of the Administration, but it is really tedious, then the lawyers will identify what the obstacles are, and then things do not proceed.

Dr. Garza suggested that Mr. Auerbach present the information about the tools to Mr. Rothwell's group so that they could begin thinking about how to approach the issue of linking the data.

Mr. Auerbach liked this suggestion. He said that he has talked to Mr. Rothwell, but has not shared this with him.

Dr. Richardson suggested pulling in the labor, IRS, and transportation data. She noted that there are some models of how data linkages are done at the local level. For example, the Chair of the HDS who preceded her developed a local website that pulled in data from various sectors, and she also saw a presentation on Philadelphia that had a similar tool.

Dr. Ross provided Mr. Auerbach with the suggested language that he requested earlier, which he said he would share with the STLT Subcommittee.

Motion / Vote

Dr. Richardson pointed out that in the past, the STLT and HDS have endorsed each other's recommendations, thus adding the weight of not one but two subcommittees when the recommendations are put forth to the ACD. Therefore, she said she would entertain a motion as to whether the HDS would like to endorse either or both of the STLT Subcommittee recommendations presented by Mr. Auerbach. Dr. Ross made a motion to endorse Recommendations 5 and 6 as presented. Ms. Wilson seconded the motion. The motion carried with a unanimous vote by the HDS Subcommittee members.

FOA Health Equity Guidance Update and Discussion

Julio Dicient-Taillepiere, MS (Team Lead, Initiatives and Partnerships Unit, OMHHE, CDC / ATSDR) explained that his objective for this session was to discuss the work that OMHHE has been doing to support greater accountability for health equity [whenever possible] in all new, non-research program Funding Opportunity Announcements (FOAs). They have been working with the Office of the Director (OD), Program Performance and Evaluation Office (PPEO), which is under the leadership of Dr. Kathleen Ethier. The team in that office handles both the management of the FOA guidance and templates that are used across the agency, as well as the evaluation of those efforts. This office established a revised template based on feedback from the ACD in 2011. In 2012, a new directive was communicated to the CIOs. In 2014, the first template was launched based on that effort.

In 2012, we started the process for increasing health equity considerations in CDC FOAs. OMHHE was invited to participate in the design and adoption of the revised FOA template. Prior to the ACD's recommendation, there were a number of templates that were used within the agency. After 2012, the agency went from several different types of templates across CIOs to just one. Now every center, regardless of what they are funding in terms of programs, uses the same FOA template.

As part of the process for writing a new FOA, there are kick-off meetings with the CIOs to give technical assistance in crafting the FOA for the template. Having participated in these kick-off meetings, OMHHE identified challenges experienced by some of the CIOs in writing their FOAs. In consultation with the HDS, OMHHE has been reviewing examples of approaches to developing an FOA both within CDC, as well as in other federal agencies, e.g., the Substance Abuse and Mental Health Services Administration (SAMHSA). Several members of the subcommittee have provided resources and feedback. Some toolkit materials were developed, some of which were more foundational, e.g., tools to increase the capacity of

CIOs to have basic data on populations. It is not possible to talk about health disparities or health equity without first talking about the actual outcomes anticipated. For example, do you collect outcome data? Do you monitor your programs? Some CIOs have greater challenges than others. Not all CIOs have the same level of funding, staffing, or evidence base. Therefore, it can be harder for some CIOs than others to do health equity work. OMHHE has facilitated capacity building via the annual State of Health Equity and CDC Forums (SHE Forum), and the special issue of the Journal of Public Health Management and Practice on health equity released in January 2016. The kick-off meetings and technical assistance follow-up have been well received by the CIOs. Technical guidance is also given to workgroups within the agency and not just Project Officers in CIOs who are writing an FOA.

As Dr. Liburd reported earlier, there have been some new additions to the Initiatives and Partnerships Team. The intent of adding people like David Delozier and Corinne Fukayama is to allow for greater capacity to engage in across-agency monitoring that the office is positioned to do, but has not had the capacity to do consistently.

Mr. Dient-Taillepiere provided a quick summary of what happened in terms of changing the template. The first time they attempted to change the template was for FY2014. They conducted review of FOAs, had a sense of how FOAs are written prior to giving feedback, and limited their feedback primarily to adding two categories to the template. No one can get through the template without having to deal with these two categories. They have to explain the target population that will be the focus and how they will address the process of inclusion in terms of a participatory approach. That is, how will the end-users be involved in the receipt of services and the evaluation of the activities. The FY 2014 template has been modified for the FY2017 version, which was just published in October 2016 and people are currently using this version. The FY2017 version includes a new category for health disparities which includes language for health equity and social determinants of health. Below is the difference between the FY2014 language and the FY2017 language:

Target Populations

Past (FY 14)

- Target Populations: If applicable or required, describe the extent to which applicants are expected to target specific populations, to target populations at greatest risk, and to achieve the greatest health impact, including health equity.

Current (FY 17)

- Target Populations: A target population is a group that will benefit from achieving the outcomes specified in the logic model. Describe the extent to which applicants are expected to target specific populations or target populations at greatest risk (e.g., based on race, ethnicity, gender) to achieve the greatest health impact, including health equity.
- When a strategy focuses on specific target populations, either require applicants to define the target populations or allow applicants to identify populations in their jurisdiction based on relevant criteria (e.g., health risk, public health impact).
- Consider opportunities for inclusion of the target populations in the planning, implementation, and evaluation of the program.

Inclusion

Past (FY 14)

- Inclusion: If applicable, describe how the FOA will include populations who can benefit from program strategies and prioritize populations with the greatest health disparities. Whether serving a geographically defined or targeted population, CDC programs must strive to include people with disabilities; non-English speaking populations; lesbian, gay, bisexual, and transgender (LGBT) populations; people with limited health literacy; and/or populations that may otherwise be overlooked by the program.

Current (FY 17)

- Health Disparities: Describe how the FOA will reduce health disparities and improve social determinants of health among populations at greatest risk. Populations that may be overlooked by the program such as people with disabilities, non-English speaking populations, tribal populations, people who live in rural areas and other geographically underserved communities, sexual and gender minorities, and people with limited health literacy must also be considered.

Definitions Added

- Health Disparities
- Health Equity
- Health Inequities
- Inclusion

A set of “tip sheets” is being developed and webinars will be created to assist staff with addressing health disparities in their programs. While OMMHE continues to look at the process of how FOAs get rolled out (kick off meeting, objective review, selection and awarding), they will also socialize issues related to health disparities, SDOH, health inequities, etc. and promote concrete ways to address these issues. In addition, they will launch intra-agency web-based resources, develop FOA monitoring and evaluation indicators, and plan a roadshow to CIOs.

CDC is actively pursuing compliance with Section 1557 of the ACA – a non-discrimination rule. Consistent with the rule, CDC has added a statement to its website that public health information is available or can be translated into 15 languages. CIOs are still fleshing out exactly how they will meet this language requirement.

Discussion Points

Dr. Ross asked whether the issue with regard to obtaining the portfolio information pertained to a technology or a data limitation issue.

Mr. Dient-Taillepierre replied that it was both. It is primarily a technology issue wherein people thought that if a system was created, people would populate it and information could be extracted from the system. Finding a system that every CIO could use has not been possible. PGO has gone through a major reorganization because of these problems with being able to just provide basic information about funds. There also is a data inputting question that is occurring among the CIOs regarding what is relevant to put in a summary in the system. That is, what would be the salient outcome data, attributes, demographic characteristics, or all of the above that would be sufficiently concise to enter into the system such that information could be extracted? When they did have the outdated system IMPAC II, he would see some of the attempts people made to populate the sections and it was wrong and did not

get to what they wanted. However, there was not an institutional way to train people on what to do to ensure the right information was provided. While they are finding a way to streamline an electronic system that will allow for the aggregation of budgetary and programmatic information, they know that they are going to need to train people on the specific data points.

To give the HDS members an idea of scope, Dr. Richardson asked how many FOAs the CDC issues annually.

Mr. Dicient-Taillepierre responded that on average, between 55 and 60 awards are made each year. This number was a lot less than initially believed, because only new non-research FOAs are counted and not continuations or sole source FOAs. Research FOAs are different, and there is a separate template for research funding. He was not aware of whether the research template included health equity.

Ms. Wilson indicated that she, Dr. Horner-Johnson, and Mr. Vargas were part of the workgroup. One of the limitations was staffing. SAMHSA has Disparity Impact Statements, so applicants have to discuss what subgroups they will work on and participation and compliance is being monitored. So, if an applicant stated that they planned to work on behavioral health in the African American population, but they do not have a single African American in the group, they will make them rework the group or take their money back. There are a number of operational distinctions between SAMHSA and CDC that make it difficult for CDC to have this same level of accountability.

Dr. Richardson pointed out that in addition to knowing of the 55 to 60 FOAs issued, it is also important to know how many actually contained the health equity language from the template, and how many of the applications received in response to the FOAs actually did whatever was in the FOA. This may be challenging, but it could be made a criterion on which the application reviewers must comment in terms of presence or absence. Mr. Dicient-Taillepierre concurred.

Dr. Liburd indicated that there is a new system called GrantSolutions.gov, in which there was a huge investment. Whenever changes are made to any words, there is a cost. They were able to make the changes shown without adding anymore words or whatever would increase the cost. PGO is reluctant to make changes to the template because of the added cost.

Mr. Dicient-Taillepierre added that there is a specified time during which they can make changes, which is before the next fiscal year. The new issue for the editorial calendar comes out in October of each fiscal year, so now they know to submit their feedback before that deadline. They are starting to routinize their involvement in the FOA.

Dr. Lichtveld said that now that she understood the template better, she realized that it was guidance rather than extra language. From the 55 to 60 that are new, she asked how many have translated to a C+.

Mr. Dicient-Taillepierre said he did not have an exact number, but it is low. It is low because they made a strategic decision in FY14 that the main argument would be to get everyone to deal with program evaluation and monitoring. The logic model became the biggest hurdle to overcome. There have been dozens of trainings every year since 2014 on just the issue of what constitutes a program, how to monitor a program, how to evaluate a program, how to collect data to monitor a program, what the Project Officer's role is, embedding it in the Project Officer training, et cetera. Like OMHHE, PPEO is very

small. However, OMHHE has been supporting the work of PPEO to make sure that the foundation is a stepping stone that will be solid enough so that they can talk about more complex data collection, monitoring, and evaluation around activities related to health disparities.

Dr. Lichtveld pointed out that literacy is beyond speaking one's own language. It is being able to write. She also stressed that they cannot give an automatic free pass to existing FOAs. It is the applicant's job to look at all of the notes, modifications, et cetera. It is an issue of willingness, not a bureaucratic thing. It will not cost a dime. If an applicant wants that money, they better be looking at that site.

Dr. Liburd indicated that there will be tip sheets that correspond to each of the requirements that provide further guidance and will include references to other supportive materials that the FOA writer can use.

Dr. Horner-Johnson said she recalled that they had conversations early on about basic science, and wondered why this applied to non-research grants but not research grants and if there was a plan to expand this effort to research FOA templates.

Mr. Dicient-Taillepierre clarified that it was just that the specific recommendation that drove the refreshing of the FOA template was specific to program FOAs. There is a separate process, committee, and mechanism for scientific FOAs in which he has not been involved. He has raised the question regarding whether this effort will be expanded to research FOA templates; however, he had not yet received a response.

Dr. Hasbrouck asked whether, after this is baked into the actual FOA, there is guidance pertaining to how it is to be evaluated by reviewers, or if it is completely qualitative in terms of whatever the Technical Monitor and Project Officer think.

Mr. Dicient-Taillepierre said he thought eventually the tip sheets would include information about measurement and weighting. The first question regards what constitutes a good example. There is the issue of program evaluation, but there also is the issue of what constitutes a health equity program. How do you measure that? How do you know it is a health equity program? How do you bake that in? That is a long-term conversation.

Dr. Liburd emphasized that these are big conceptual and methodological questions. There always is an evaluation sheet that accompanies an FOA, which she thought could be negotiable each time with the program in terms of how much to weight each component. Being closely involved with this part is important, particularly because this is new and they would like for it to have a strong start. They are doing everything they can to elaborate and articulate what these things mean, what they look like, et cetera.

Dr. Ro pointed out that this has been in the works. When this conversation began in 2012, part of it regarded having another tool to help increase the adoption or integration of the health equity lens internally. It also was to use the influence that CDC outwardly applied to external partners to emphasize that health equity is a huge priority. She thought Dr. Liburd mentioned that they were about to conduct another round of the employee environment survey at CDC.

Dr. Liburd clarified that the CDC Diversity Culture Audit was completed in August, and they are going to be doing the roadshows to share the results. There is an employee feedback survey that is administered every year, typically in the early spring.

Dr. Ro asked whether the employee feedback survey includes a health equity section. Seattle-King County conducts an annual survey of employees, which includes a health equity section that asks employees about their perception of health equity and whether they feel like the health department is on track. She was hearing that there was pushback and she was wondering where that came from. She heard that there was an issue regarding finance, but also wondered about how far they are getting in terms of health equity as a priority and understanding that if they only have limited resources, where should they be expending these? It is really important for health equity to become a priority. It could be that the CIOs are getting pushback from communities, but this was not clear to her. She wanted to know more, even anecdotally, if it was just because people were hesitant to change or if there was something more behind it.

Mr. Dicient-Taillepierre said he could say something anecdotally based on the feedback during the CIOs meetings. After the kick off meeting, the CIOs send him their initial drafts. There typically will be a lot of back and forth editorial activity. It has been interesting to hear some of the comments, which have run the gamut. He would say anecdotally that there are four top four categories. The first is early adopters who ask, "Aren't I already doing enough?" Some early adopters are doing quite a bit. What kind of feedback should they be given? Second, is the groups who are wondering, "This works. Why do I need to switch it up?" One issue he and Dr. Liburd experienced when writing the program publication was the notion that, "As long as I'm doing a program targeting this population, it's health equity." The answer is "no." Just because a program is being implemented that addresses an issue related to health disparities does not mean that it is actually reducing health disparities. The third is late adapters—people who do not have the evidence, have not targeted a population, and traditionally have farmed it out. That is, they funded the health department or community-based organizations (CBOs) and say, "Well, they're the technical experts. Our primary responsibility is a fiduciary responsibility to make sure that the money gets rolled out and that it gets spent." That is a values issue, which has been somewhat harder. That is more of an issue about what CDC's purview is as a federal agency, and that has implications for more discussion and is somewhat harder. The fourth group are the ones who ask whether health equity even has to be a priority.

Dr. Ro said they hope to see a shift in how folks are divided into those four categories. This is one piece of it. Another piece of it is for people being more explicit in who gets to benefit from that strategy or that mechanism. There is another piece of it which is changing the nature of the FOAs at large. It is not just about targeting certain populations. It is literally understanding the definition that Dr. Liburd starting them off on in terms of power, systems, processes, and so forth, the nature of the FOAs have to change over time if people have really embraced health equity. Similarly with HDS's recommendation of building community capacity, that should become something that is seen in programmatic FOAs. She said she wanted to make sure that they do not forget.

Dr. Ross asked whether there is at least the ability to identify a particular issue in health equity, and determine whether that has been addressed in every FOA. Is there functionality in the IT information systems at CDC to embed that information, make sure it is captured, and make sure that as language changes, they can modify that infrastructure without the added cost?

Mr. Dicient-Taillepierre indicated that now that they know what the calendar is and they are an integral member of the process, they can make changes to the template without there being added costs. It is just that there is a timeline. They will revisit the template every summer. As more indicators and examples are developed, these will be added to the template and the objective review process. There definitely is a systematic way to get it embedded into the system. The harder part in terms of the data input issue pertains to technical capacity. That is a much more complicated discussion.

HDS Priorities / Follow-Up Actions

During this session, Dr. Richardson indicated that she would lead the group in a discussion of action items from the previous meeting and new action items that had been generated during this meeting. Given the potential for a new Administration in 2017, consideration was given during this session regarding whether to write a letter or submit recommendations to the ACD. In addition, there was discussion pertaining to responding to the Office of Management and Budget's (OMB's) proposed changes to the "Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity." Deliberations pertaining to each are bulleted within each topic (e.g., letter, recommendations, OMB response).

Discussion Points

Transition Letter

- If a letter is to be written, it should be under the auspices of the HDS.
- A letter should articulate what has been done, the importance of it, and what HDS would like to see accomplished in the future.
- A letter would not have to be long, but the more specific it is, the more likely it will be to gain traction.
- A determination should be made regarding where a letter should be submitted (ACD, CDC, Transition Team, Sherri Berger).

Transition Recommendations

- Rather than a letter, consider submitting recommendations to the ACD modeled after the STLT Subcommittee's language reading, "The STLT Subcommittee aims to suggest important steps toward supporting this vision for public health, especially in light of transition to a new Administration in 2017."
- These recommendations would have to be submitted to the ACD on October 20, 2016 or it would be 6 more months before they would have another opportunity.
- Select 4 to 5 main action items, couch them in terms of priorities going forward, and keep this within the structure of the ACD. There was support for this approach, given that it likely would have greater impact.

- Do not include too many recommendations and too many overwhelming priorities.
- These particular recommendations should be specifically within the purview of CDC.
- Recommendations could be worded similarly to the STLT Subcommittee's with a preamble, noting the expansion of OMHHE and recognizing the efforts that Dr. Liburd and her team have made over the last few years in implementing the HDS's recommendations previously submitted to the ACD. The preamble could recoup the past, and state the principle of endorsing health in all policies and a multi-sectoral approach.
- Specific items could be recommended with regard to the data issues and the questions in CDC surveys, including something about the language question.
- Include recommendations pertaining to the way that racial and ethnic groups are aggregated or disaggregated, and how those data always should be presented.
- It is possible that taking this route could hamper direct conversations that Dr. Liburd could have with NCHS.
- The recommendations would not have to be limited to NCHS. There are numerous surveillance systems that are administered by the CIOs. The goal is to give everyone a standard to aspire to rather than leaving it up to everybody's individual level of awareness and interest.
- Make some type of statement that HDS is recommending that there be an integration of health equity principles and values throughout CDC's implementation of programs, research, and policies. That is a broad statement but it calls attention to the fact that the responsibility does not just lie in this one unit. This was the intent of Recommendation 1 in the last set of recommendations. Now they are delving into the details and perhaps should say more about moving into the implementation of this value.
- The framework Dr. Liburd showed earlier is an embodiment of Recommendation 1 and how it involves all of the programmatic, policy, and data pieces. This was designed to be an agency-wide framework.
- There are some areas of the previous recommendations where progress has moved faster than it has for others, so perhaps targeting the ones where there has been less movement should be reiterated in the opening narrative of the new recommendations.
- Some concern was expressed with the timing of the recommendations, given that they could be lost in all of the noise going on due to the transition.
- The last time the HDS made formal recommendations was in 2014. Perhaps they should follow the modus operandi of the STLT Subcommittee and as important issues are discussed in an HDS meeting, they should formulate, codify, and submit recommendations to the ACD. Timing is

important and there is going to be a lot of noise and a lot of paper generated; however, there is a sense that on this watch while they have receptive leadership, they should see what they could get put into policy. Then someone would have to dismantle it as opposed to 6 months from now trying to bring it to the attention of someone who may not be as receptive.

- One recommendation should address data in terms of how data fields are defined; collection; how data are reported; the lens through which data are analyzed; and who collects, analyzes, and houses the data. It is not a dichotomous issue of having data or not having data. The message is that there are tons of data, but they are useless because they cannot answer the questions that need to be answered.
- Perhaps the data recommendation could be worded, “CDC should improve data collection to advance health equity.”
- Because this seemed to mimic Recommendation 2 already submitted, it should say something specific about disaggregating sub-populations and using best practices in terms of asking questions about language proficiency and preferred language.
- It is not just about disaggregation. It also is about how new data would be collected to answer health equity questions.
- The National Collaborative for Health Equity is in the process of developing indicators, which is a process that was started in response to Recommendation 2. In terms of specific metrics, data elements, categories, et cetera perhaps HDS should wait to see what they proposed.
- Given that there are 6 existing recommendations, perhaps there should be historical reflection about what has been achieved, and then identify one or two new recommendations about priorities.
- Dr. Richardson always gives ACD an update on what has been accomplished with regard to the existing 6 recommendations. She emphasized that she would like to know whether there were a couple of specific recommendations she could add to this update that were new.
- The data granularity issue does not apply only to race and ethnicity data. It also applies to disability data, types of disability, degree of impact, length of limitation (lifelong disability versus disability acquired later in life), and the relationship to health disparities.
- Maybe a way into that is to talk about the way existing data and data elements are handled and the data elements that are not routinely included in data collection efforts, followed by issues pertaining to disability, gender identity, sexual orientation, et cetera. These are orders of magnitude different problems. Some are getting it but are not handling it in the way it needs to be, and others are not even getting these data.
- Trying to gather SDOH data is very challenging.

- The FOA language should be updated to support and encourage health equity. Although this has been identified as something already happening, it is important to keep it right in front of people. Perhaps something could be included to acknowledge the progress and emphasize the need to take this to the next level by incorporating the language not only into the FOA, but also into the review of applications and monitoring of outcomes.
- Dr. Ro proposed the following draft language, which she said she would further flesh out and send to everyone for review, “CDC should improve data collection to improve health equity. Data should be disaggregated whenever possible in the analysis and dissemination of data findings. Survey questions capturing race, ethnicity, and language should reflect the best practices. Attention should be placed on data policies that allow for linkage of health data with data on SDOH, or to link existing datasets from other agencies. Data are also needed on other special populations, such as people living with disabilities.”
- The preamble could state something about CDC working in an interagency manner with other agencies, inside and outside of HHS, that can help to support the work pertaining to health equity. Perhaps there could be an Interagency Task Force or Working Group.
- Ms. Thompson suggested the following language, “In order to achieve health equity, it is important for CDC to work with other agencies in order to support the goal toward achieving health equity by creating relationships, alliances, and partnerships.”
- This seems similar to one of the STLT Subcommittee’s recommendations pertaining to SDOH. Perhaps it could be reiterated in the preamble.
- There is some redundancy, so a couple of recommendations could be collapsed. The recommendations should be as condensed as much as possible.
- The ability to increase capacity-building among public health agencies and community-based agencies could be achieved by advocating for health equity and SDOH to be embedded into the public health agency accreditation model.
- Another possible recommendation would be to ensure that recommendations being brought forth by all of the other subcommittees include how health equity fits into their recommendations. One example would be electronic case reporting and ensuring that whatever is implemented is done through the lens of health equity. That could be an overarching recommendation.
- Consideration should be given to “low-hanging fruit” versus strategic, what will make it after the Transition Team, and what language people speak. If they are clear about the examples of the power of data, that would be concrete and people would understand that.
- Indicate to ACD that a Health Equity Framework has been developed and that it would be great for the highest leadership to approve or adopt this framework. Dr. Richardson thought they would

have to show ACD the framework and explain it before they would take any action based on the framework, which would take more time than she would be allotted the next day. Rather than October 20th, perhaps this should be proposed for the next ACD agenda. By that time, it will have been polished and vetted and they can formulate all of the ways in which they would like to see this rolled out, used, et cetera. Dr. Liburd should present the Health Equity Framework.

Motion / Vote

Dr. Richardson indicated that for the record, she would entertain a motion for each of the following 2 recommendations that she would present on behalf of HDS to the ACD during its October 20, 2016 meeting:

Recommendation 1

This recommendation will address the way that currently collected data are presented; identify important data elements that should be collected throughout all of CDC data collection efforts, not just NCHS; and call out the electronic case reports. A motion was made, seconded, and unanimously approved.

Recommendation 2

This recommendation will address the notion that health equity should not only be included in FOA template language, but also should be incorporated into the application review process and the monitoring of outcomes. A motion was made, seconded, and unanimously approved.

Dr. Richardson indicated that later in the evening, she would share with the HDS members the specific wording of the recommendations just passed as they would be presented to the ACD on October 20, 2016.

OMB Proposed Revisions

- Overview: The Office of Management and Budget (OMB) has proposed revisions to the “Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.” OMB formed an Interagency Working Group for Research on Race and Ethnicity to review the 1997 standards. The Working Group identified four areas for which revisions might improve the quality of race and ethnicity information collected and presented by federal agencies: 1) The use of separate questions versus a combined question to measure race and ethnicity and question phrasing; 2) the classification of a Middle Eastern and North African group and distinct reporting category; 3) the description of the intended use of minimum reporting categories; and 4) the salience of terminology used for race and ethnicity classifications and other language in the standard [*Federal Register* / Vol. 81, No. 190 / Friday, September 30, 2016 / Notices].
- Ms. Wilson explained that the 2-question approach asking Latino / Hispanic first and then categories, race a combined single question design would be used. There also is the issue of having a subgroup of Middle Eastern and North African subgroups, which are aggregated in the reporting category of “White.” Minimum categories are often misinterpreted as being limited to the minimum categories, so the goal would be to improve the language to better explain the intended use of the minimum standards to encourage more granular data collection. The proposed addition

of clarifying terminology is because people tend to report “principal minority race” such that it becomes White / Non-White. Comments are due by October 31st. The first issue is collapsing the two separate questions: 1) Are you Hispanic / Latino? Yes / No; 2) What race do you consider yourself? Oftentimes, people who choose Hispanic or Latino do not choose a race. Some would choose some other race. Having a single question should result in less confusion about race versus ethnicity.

- Concern was expressed about the focus on just these specific subgroups. It should include all of the racial categories. Asian / Pacific Islander should be disaggregated as well. There are some extraordinarily sophisticated categorization schemes that have all of the possible subgroups. There are 10 other groups for whom a similarly valid rationale could be presented, so it was not clear why only certain groups were being targeted.
- Middle Eastern / North African as a subgroup has been an increasing issue. Students from North Africa list themselves as “Black” and some people from the Middle East refer to themselves as “White.”
- Ms. Wilson will develop comments about each of the four proposed changes, including examples, and will send them out to the HDS members for review.
- These can be submitted as public comments by the HDS through the *Federal Register*.

Health Equity Indicators: Workforce Diversity Indicator, the National Collaboration for Health Equity

Ana Penman-Aguilar, PhD, MPH (Associate Director for Science, OMHHE, CDC / ATSDR) described the progress that has been made on the HDS recommendation that was adopted by the ACD for CDC to establish and monitor health equity indicators. To address this recommendation and ensure that efforts are not duplicative in an environment flooded with new indicators, OMHHE is participating in the National Collaborative for Health Equity (NCHE) effort to create a National Health Equity Health Opportunity Index. CDC saw these efforts and the efforts of HDS member David William in this area as promising because of the desire to capture what is happening or not happening in health equity as an opportunity. A lot of activity over recent months has been fielding technical questions from NCHE. She said she would be remiss if she did not give kudos to colleagues from NCHS, who provided most of the nitty gritty technical information that the collaborative has needed.

In terms of progress on the Health Opportunity Index, she was able to get an update that by December 2016, an analysis will have been completed of two domains: health outcomes and income. Within 3 to 6 months, a framing document will be published. It is anticipated that the project will be completed by June 2017. The question moving forward essentially will be, “What does this nascent method of monitoring health equity mean for the CDC?” Ultimately, they want to piggy-back on what is going on with the collaborative and bring that back to CDC.

Another concept related to the same recommendation is the development of a Public Health Healthcare Workforce Diversity Indicator. It is known that workforce diversity is facilitated or impeded by structural factors resulting in conditions in the environment in which we live, work, and play that affect the health

of individuals in communities. The evidence for the importance of racial / ethnic concordance in the healthcare arena is telling. This supports the importance of diversity of the healthcare workforce, and the commitment to understanding the diversity of the public health workforce. The arguments for the importance of this diversity are compelling. They are embarking on an effort to monitor racial / ethnic diversity and gender diversity of the public healthcare workforce. The plan is to attend to and shine a light on gaps in things that cannot be monitored nationally or going down to different levels of geography at this point with regard to sexual orientation, gender identify, disability status, and other factors. The word needs to get out there are glaring gaps in those areas. They also want to identify other gaps that would make this effort less about diversity than demographics, so they have been speaking at length with the Diversity and Inclusion Management area and OMHHE to ensure that as they look at diversity, they are thinking about it through a lens of inclusion as well. As discussed in previous meetings in terms of decision-making, this needs to be more than counting people. If they are looking at diversity through a health equity lens, it has to be about real and meaningful diversity and inclusion. They view the SDOH as upstream from Healthy People 2020 Social Determinants Indicators that depend on the provision of culturally and linguistically appropriate services, such as having a medical home. However, this only touches on the broader picture of how diversity of the public health workforce ultimately affects programs in prevention, et cetera.

The Science Team, in collaboration with partners at the NCHS, conducted a literature review and created an annotated bibliography. Dr. Jeffrey Hall, the new ADS, has been working with a very talented undergraduate to complete the literature review and bibliography. Now they are getting into the work of identifying and comparing candidate indicators. During the last HDS meeting, the members requested interim involvement. Whether they knew it or not, the HDS members have been somewhat involved by proxy. The team recently had a call with Dr. Will Ross and was able to get his perspective regarding whether he saw any glaring gaps in the literature review. Happily, he did not see any huge gaps. They thought they would involve a larger circle once they are further along, so she and Dr. Hall anticipate reaching out to more the HDS members in a couple of months.

Discussion Points

Dr. Ro appreciated all of the work that had gone into the literature review, but thought that there was more on the editorial side in the literature talking about what skill sets and perspectives will be needed for the public health workforce of the future. Perhaps there are data on this. She thinks a lot about urban planning, community development, justice, working multisectorally, et cetera. She asked whether any thought had been given to looking at that perspective in the literature review.

Dr. Ross indicated that they shared information about the competencies expected out of graduates of schools of public health, schools of medicine, nursing, et cetera. That was part of the literature review. The major evidence is in Richard Riegelman's expansive review of public health competencies.

Building on Dr. Ro's question, Dr. Lichtveld pointed out that one of the efforts that has received increasing traction is the inter-professional education (IPE) effort that is going across multiple associations (medicine, nursing, dentistry, pharmacy). Some publications and competencies have come out. There was one a couple of years ago on cultural competence, and one more recently on population health. These can be found on the Association of American Medical Colleges (AAMC) AANC website. This looks at what the future professional needs to know to work from a population, community-driven perspective rather than the old individual medical model.

Dr. Wooten asked what the next step would be and how the data gathered will be utilized to move forward.

Dr. Penman-Aguilar replied that they will be looking at candidate indicators, comparing them, filling out a matrix in terms of what they want to know, what questions need to be asked for the data that do not exist, whether there are data sources, what the limitations are when there are data sources, et cetera. One question regards how to disseminate the work, and have discussed completion of a product. They are open to discussing what that project might be.

Dr. Ro asked whether they had worked with anyone at the de Beaumont Foundation, and if not, suggested reaching out to them as a valuable resource. They have done a lot of work on the public health workforce and have conducted a couple of surveys. This would be a nice way to marry the two efforts.

Dr. Lichtveld pointed out that competencies typically focus on knowledge, skills, and abilities. In the case of health equity, it is critical to include attitude. It is about people and attitudinal competencies.

Dr. Wooten indicated that the Big Cities Health Coalition (BCHC) has a workgroup focused on workforce. They are using some of the work that has been done by the de Beaumont Foundation. As a participant, she has staff working on that workgroup and she is really excited about what the outcome of that work is going to be. She suggested that Dr. Penman-Aguilar be involved in that process so that the two processes could be integrated in some way.

Dr. Penman-Aguilar indicated that they have looked at de Beaumont Foundation's work, but have not contacted them. She will follow-up by email with Drs. Wooten and Ro for contact information. She requested that the HDS members let Dr. Richardson know who would like to be a part of the call she and Dr. Hall will be having in a couple of months.

Public Comment

Dr. Richardson opened the public comment period at 3:38 p.m. and invited members of the public to make a statement or raise a question. With no questions or comments presented from the public, the public comment period was closed at 3:47 p.m.

Closing Remarks / Adjourn

Dr. Richardson thanked the HDS members for their extremely lively discussions, the productive work in terms of gaining some traction in actually doing things that are likely to have impact, and finding the role they can play as a subcommittee to help move the work forward. With the newly augmented staff at OMHHE, she thought they would be able to do more about moving the work forward in between meetings. She suggested establishing workgroups to flesh out some of the ideas that were floated during this meeting, so that they could come to the next meeting with some action items. Suggested workgroups included:

- Indicator Workgroup
- Data Think Tank (either within HDS or combined with the STLT Public Health Surveillance Think Tank): Dr. Ro, Dr. Horner-Johnson, Ms. Wilson expressed interest

Others interested in being on the Indicator Workgroup or Data Think Tank were requested to email Dr. Richardson. It was noted that even though some members will rotate off of the HDS, they may still participate in workgroups. It was suggested that a conference call be convened between the scheduled HDS teleconferences and in-person meetings typically convened in February, April, August, and October.

With no additional business raised or comments / questions posed, Dr. Richardson wished everyone safe travels and officially adjourned the meeting at 3:54 p.m.

Certification

I hereby certify that, to the best of my knowledge and ability, the foregoing minutes of the October 19, 2016, meeting of the Health Disparities Subcommittee of the Advisory Committee to the Director, CDC are accurate and complete.

Date

Lynne D. Richardson, MD, FACEP
Chair, Health Disparities Subcommittee, Advisory Committee to
the Director, CDC

Attachment #1: Meeting Attendance

HDS Members Present

Mary Garza, MD, MPH

Assistant Professor & Associate Director
Maryland Center for Health Equity
University of Maryland School of Public Health

Graham, Garth, MD, MPH

President
Aetna Foundation

LaMar Hasbrouck, MD, MPH

Executive Director
National Association of County and City Health Officials (NACCHO)

Willi Horner-Johnson, PhD

Associate Professor
Oregon Health and Science University
Institute on Development and Disability

Anthony B. Iton, MD, JD, MPH

Senior Vice President
Healthy Communities, The California Endowment

Maureen Lichtveld, MD, MPH

Professor and Chair
Freeport McMoRan Chair of Environmental Policy
Associate Director of Population Sciences, Louisiana Cancer Research Consortium
President, Hispanic-Serving Health Professions Schools
Tulane University School of Public Health and Tropical Medicine

Lynne D. Richardson, MD, FACEP (Chair)

Professor and Vice Chair of Emergency Medicine
Professor of Population Health Evidence and Policy
Icahn School of Medicine Mount Sinai

Marguerite Ro, DrPH

Chief, Assessment, Policy Development, and Evaluation Section
Public Health Seattle-King County

Will Ross, MD, MPH

Associate Dean for Diversity and Assistant Professor of Medicine
Washington University School of Medicine Office of Diversity

Mildred Thompson, MSW

Senior Director (retired)
PolicyLink Center for Health Equity and Place

Hector Vargas, JD

Executive Director
Gay, Lesbian Medical Association (GLMA)
Health Professionals Advancing LGBT Equality

Cheri Wilson, MA, MHS, CPHQ

Faculty Research Associate
Health Policy and Management Department
Program Director, Culture-Quality-Collaborative

Wilma J. Wooten, MD, MPH

Chair, STLT Subcommittee
Public Health Officer
County of San Diego Health and Human Services Agency

HDS Members Absent

David Fukuzawa, MDiv, MSA

Program Director-Health
The Kresge Foundation

Anthony B. Iton, MD, JD, MPH

Senior Vice President
Healthy Communities, The California Endowment

CDC / ATSDR Staff Present

John Auerbach, MBA

Associate Director for Policy
Office of the Associate Director For Policy

Sharon R. Coleman

Associate Director for Policy
Office of Minority Health and Health Equity

Julio Dicent-Taillepierre, MS

Public Health Analyst / Team Lead
Initiatives and Partnerships Team
Minority Health and Health Equity Unit
Office of Minority Health and Health Equity

Melanie Duckworth, PhD

Senior Advisor to the Director

Office of Minority Health and Health Equity

Jeffrey E. Hall PhD, MSPH

Deputy Associate Director for Science
Office of Minority Health and Health Equity

Sonja S. Hutchins, MD, DrPH, MPH

Medical Epidemiologist
Office of Minority Health and Health Equity

Leandris Liburd, PhD, MPH, MA (Designated Federal Officer)

Director, Minority Health and Health Equity
Centers for Disease Control and Prevention

Judy Lipshutz, MPH

Public Health Analyst
Office of State, Tribal, Local and Territorial Support

James Nelson, PhD

Chief, Diversity and Inclusion Program
Office of Minority Health and Health Equity

Ana Penman-Aguilar, PhD, MPH, BA

Associate Director for Science
Office of Minority Health and Health Equity

Laura Ross, PhD

Associate Director for Communications
Office of Minority Health and Health Equity

Charles Rothwell, MBA, MS

Director
National Center for Health Statistics

Anne Schuchat, MD, BA

Principal Deputy Director
Office of the Director

CAPT Craig S. Wilkins, MPH

Senior Advisory to the Director
Office of Minority Health and Health Equity

Others Present

August Pollak, MS

Medical & Scientific Writer/Editor
Cambridge Communications & Training Institute

Attachment #2: Acronyms Used in this Document

Acronym	Expansion
AAMC	Association of American Medical Colleges
ACA	(Patient Protection and) Affordable Care Act
ACD	Advisory Committee to the Director
ADC	Associate Director of Communications
ADP	Associate Director for Policy
ADS	Associate Director of Science
AI / AN	American Indian and Alaska Native
ATSDR	Agency for Toxic Substances and Disease Registry
BCHC	Big Cities Health Coalition
CBO	Community-Based Organization
CDC	Centers for Disease Control and Prevention
CHI	Community Health Improvement Navigator
CHSI	Community Health Status Indicators
CHW	Community Health Worker
CID	Center for Infectious Diseases
CIO	Centers, Institutes, and Offices
CMS	Centers for Medicare and Medicaid Services
CSELS	Center for Surveillance, Epidemiology and Laboratory Services
CSHO	Customized Support for Health Officials
CUPS	CDC Undergraduate Public Health Scholars
DCH	Division of Community Health
DFO	Designated Federal Officer
DGMQ	Division of Global Migration and Quarantine
DOJ	Department of Justice
DVP	Division of Violence Prevention
EHR	Electronic Health Records
EPA	(United States) Environmental Protection Agency
FACA	Federal Advisory Committee Act
FDOH	Florida Department of Health
FOA	Funding Opportunity Announcement
FRN	<i>Federal Register Notice</i>
GAP	Global AIDS Program
GCC	Global Communications Center
GIH	Grantmakers in Health
HDS	Health Disparities Subcommittee
HHS	(United States Department of) Health and Human Services
HiAP	Health in All Policies
HP	Healthy People
HPSB	Health Promotion Statistics Branch
HUD	(United States) Department of Housing and Urban Development
IOM	Institute of Medicine
IPE	Inter-Professional Education

Acronym	Expansion
IPV	Intimate Partner Violence
IRS	Internal Revenue Service
KKI	Kennedy Krieger Institute
LAP	Language Access Plan
LGBT	Lesbian, Gay, Bisexual, Transgender
MASO	Management Analysis and Services Office
MD	Medical Doctor
MMWR	<i>Morbidity and Mortality Weekly Report</i>
MoH	Ministry of Health
MPH	Master of Public Health
NACCHO	National Association of County and City Health Officials
NAM	National Academy of Medicine
NCBDDD	National Center for Birth Defects and Developmental Disabilities
NCCDPHP	National Center for Chronic Disease Prevention and Health Promotion
NCEZID	National Center for Emerging and Zoonotic Infectious Diseases
NCHE	National Collaborative for Health Equity
NCHHSTP	National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
NCHS	National Center for Health Statistics
NCIRD	National Center for Immunization and Respiratory Diseases
NHIS	National Health Interview Survey
NCPHI	National Center for Public Health Informatics
NHANES	National Health and Nutrition Examination Survey
OADP	Office of the Associate Director for Policy
OCR	Office of Civil Rights
OD	Office of the Director
ODPHP	Office of Disease Prevention and Health Promotion
OGH	Office of Global Health
OMHHE	Office of Minority Health and Health Equity
ONDIEH	Office of Noncommunicable Diseases, Injury and Environmental Health
OSELS	Office of Surveillance, Epidemiology and Laboratory Services
OSTLTS	Office for State, Tribal, Local and Territorial Support
OWH	Office of Women's Health
PGO	Procurement and Grants Office
PHAB	Public Health Accreditation Board
PHPPO	Public Health Practice Program Office
PMI®	Precision Medicine Initiative®
PPEO	Program Performance and Evaluation Office
REACH	Racial and Ethnic Approaches to Community Health
RWJF	Robert Wood Johnson Foundation
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Surveillance Branch
SDOH	Social Determinants of Health
SES	Socioeconomic Status
SME	Subject Matter Expert
SMO	Senior Management Official

Acronym	Expansion
STLT	State, Tribal, Local, and Territorial (Subcommittee)
US	United States
UWPHI	University of Wisconsin Population Health Institute